Maternal and Child Health Services
Title V Block Grant

State Narrative for Missouri

Application for 2013
Annual Report for 2011

Document Generation Date: Monday, September 24, 2012

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Copies of the Title V Assurances and Certifications may be obtained by contacting:

Bret Fischer, Director
Division of Administration
Missouri Department of Health and Senior Services
PO Box 570
Jefferson City, MO 65102-0570.

Phone: (573) 751-6014
FAX: (573) 526-6049

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Public input was obtained throughout the past year as part of routine staff communication and participation in coalitions, advisory boards, conferences, and professional and community meetings. For examples of the types of agencies and organizations involved see Section III.E. State Agency Coordination.

The Proposed Use of Funds for the Maternal and Child Health (MCH) Block Grant application was posted from April 30, 2010 to May 28, 2010 on the Department of Health and Senior Services' (DHSS) website (www.dhss.mo.gov). The Proposed Use of Funds was e-mailed to 337 various public contacts including council members, community partners, Local Public Health Agencies (LPHAs), health care professionals, and industry leaders. In addition, the Missouri Chapter of the American College of Obstetricians and Gynecologists forwarded the information to 450 of its members. Ads were placed in the St. Louis, Kansas City, Springfield, Columbia, Kirksville, and Cape Girardeau newspapers to notify the public of the document's location on the internet and the contact information to request hard copies.

The DHSS website with the Proposed Use of Funds had a total of 118 hits, 5 internal (includes LPHAs) and 113 external.

Responses were received from 35 individuals representing a wide variety of organizations and interests. Of those, 11 expressed their support for the maternal and child health activities proposed and 4 requested additional detailed information on overall MCH related activities. General themes which appeared throughout the majority of the comments included the need to

support oral health, injury prevention activities, prevention of teen pregnancy, adolescent health, and breastfeeding.

In particular, the Greater Missouri Chapter of the March of Dimes wrote:

"March of Dimes would like to applaud the Department's efforts to protect and improve the health of women and children across the state. Our newborn screening program is one of the strongest in the nation and in 2009 March of Dimes was proud to honor Missouri with the National Award for Excellence in Newborn Screening. The budgeted funds to maintain and improve these services are essential and we fully support the Department's work.

March of Dimes is also in favor of the Department's inclusion of services and infrastructure building to provide a network of care which will prevent birth defects, prematurity and infant mortality. Missouri has lowered its prematurity rate from 13.3% in 2005 to 12.3% in 2008 according to the National Center for Health Statistics. Many of the population-based services covered by the Title V Block Grant are related to these health issues - specifically, the programs on Folic Acid and Alcohol, Tobacco & Other Drugs Prevention and Awareness. Along with the infrastructure established through the grant, these services continue to protect the most vulnerable Missourians."

The Catholic Charities of Kansas City-St. Joseph, Inc. stated: "We are pleased with the diversity of services and programs supported through this funding source. We also appreciate our continued partnership with DHSS through the Adoption and Foster Care Coalition and the opportunity to continue to serve young families in Missouri."

Other individual comments focused on obesity, sickle cell, SIDS, home visiting and Parents as Teachers. All of the comments focused on areas which are specifically one of the 10 identified Missouri Priority Needs or on an activity which directly relates to one of the Priority Needs. Each comment was reviewed and responded to by the Title V Director. The input received from these comments has been incorporated into the plan where appropriate.

/2012/Public input was solicited in a similar method to last year. Missouri chose to distribute a summary document (Proposed Use of Funds) for public comment. In addition, this year Missouri completed a Summary of the MCH Needs Assessment and distributed with the Proposed Use of Funds. Both documents were posted from April 29, 2011 to May 18, 2011 on the Department of Health and Senior Services' (DHSS) website (www.health.mo.gov). The Proposed Use of Funds and Needs Assessment Summary were e-mailed to 388 various public contacts including council members, community partners, Local Public Health Agencies (LPHAs), health care professionals, and industry leaders. Ads were placed in the St. Louis, Kansas City, Springfield, Columbia, Kirksville, and Cape Girardeau newspapers to notify the public of the document's location on the internet and the contact information to request hard copies.

Responses were received from 15 individuals. Ongoing flooding issues in the southeast area of the state during late April through mid May may have impacted the number of responses received. Comments were overall supportive and continued to express the needs in a variety of MCH related areas.

One comment from the Platte County Health Department provides a good summary of the MCH work in Missouri.

"The MCH block grant funding is regarded in our community as essential funding to address identified issues of concern for pregnant women, infants, children, adolescents, and/or families in Platte County as well as the entire state of Missouri.

Prevention dollars have been slashed in numerous arenas, at a time when assistance is truly needed the most. Professional agencies and valued partners that historically provided the safety

net for our nation's indigent population are vanishing, and the public health departments and local communities at large are expected to provide assistance and prevention education without additional funding. The MCH funding had already been operating on bare minimum dollars.

Platte County community stakeholders have stepped forward and have committed to working together, sharing resources to ensure that priority issues being addressed are consistent, with common goals and expectations. Platte County has already created a three year strategic plan to utilize and stretch the MCH "seed funding" dollars thru 2014.

The MCH funding are crucial and critical prevention dollars. The MCH funding is necessary to ensure that ongoing assessments correlate with community goals and systemic changes. The MCH funding will provide valued child care trainings and positive social norming campaigns designed to target local issues that will keep our community safe and healthy."//2012//

/2013/The Proposed Use of Funds document was posted on the Department's website from May 7-28, 2012. In addition, announcements directing interested parties to this website were placed in the St. Louis, Kansas City, Columbia, Springfield, Kirksville and Cape Girardeau newspapers. These documents were also emailed to 453 individuals who participate on various Department committees such as the State Board of Health, LPHA Administrators, Coordinating Board of Early Childhood, MIECHV and ECCS Grant Steering Committees, and/or partners interested in maternal and child health issues, such as Safe Kids Coalitions, Child Advocacy Centers, etc. Twenty-two comments were received which included statements from individuals encouraging additional funds for sickle cell disease, domestic violence, blood lead screening, behavioral health and child care assistance. One physician wrote, "Using these funds to improve the health of women and children is admirable and necessary."//2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

In 2010, the Title V Agency for Missouri (Missouri Department of Health and Senior Services/Division of Community and Public Health) completed the statewide five-year maternal and child health (MCH)/children and youth with special health care needs (CYSHCN), needs assessment. The study was designed to enable Title V to assess its services in relation to the MCH needs of the state, which were identified through secondary data from the census, related data, population surveys, input from others in the community with expertise on the issues of the population served and focus groups with consumers and providers across Missouri. On April 6, 2010, 63 MCH "stakeholders" from across Missouri gathered in Jefferson City to review quantitative and qualitative data compiled towards the needs assessment. The stakeholders were presented with data from statewide focus groups and epidemiological trends on select MCH indicators to provide them with an idea of Missouri's standing with respect to national performance measures, current state performance measures and current state MCH priorities. The top ten Missouri MCH priorities identified through the needs assessment process in relation to the MCH pyramid of health services are as follows:

INFRASTRUCTURE

Support Adequate Early Childhood Development and Education - Collaborate to coordinate efforts through leadership roles in interagency coalitions for the purpose of better targeting existing resources for early childhood development and education, identifying gaps in service delivery and infrastructure, and pursuing necessary resources to address these identified areas.

Improve the Mental Health Status of MCH Populations - Collaborate with state and local partners to develop/enhance mental health infrastructure. Identify strategies to streamline existing resources and integrate mental health services into primary care. Focus will be on preventive mental health services particularly among new mothers, children and adolescents.

POPULATION-BASED SERVICES

Reduce the Rate of Teen Pregnancies and Births - Collaborate with state, local and non-profit agencies involved with teen pregnancy prevention activities through technical and programmatic support. Focus will be on comprehensive education as part of the life course perspective to prevent teen births/pregnancies.

Prevent and Reduce Smoking Among Women and Adolescents - Collaborate with statewide partners to reduce the number of women and adolescents who smoke.

Reduce Obesity Among Women, Children and Adolescents - Collaborate with statewide partners to achieve healthy weight among the MCH population through increased physical activity and healthy eating habits.

Reduce Disparities in Adverse Birth and Pregnancy Outcomes - Collaborate with state and national partners to examine the causes of adverse pregnancy outcomes, particularly the associated racial disparities. Implementation of evidence based interventions and novel initiatives with a life course approach will be the center piece to reduce disparities in birth outcomes.

Reduce Intentional and Unintentional Injuries Among Women, Children and Adolescents -

Collaborate with partners to implement environmental supports and policies to positively impact motor vehicle accidents/deaths among adolescents; suicide attempts/completions among adolescents; and intentional/unintentional injuries among women, children, and adolescents.

DIRECT/ENABLING SERVICES

Improve Health Care Access for MCH Populations - Provide technical assistance and resources in collaboration with other statewide partners to assure adequacy and cultural competency of provider networks which support reproductive health, primary health, oral health, and mental health/substance abuse services for women, infants/children, adolescents, and special health care need populations, with an emphasis on medical/oral health home.

Improve Preconception Health Among Women of Childbearing Age - Collaborate with state and local partners on the importance of preconception care and the need to educate women on the importance of preconception care. Enhance public health education efforts encouraging women of childbearing age to seek preconception and interconception care as part of the life course perspective.

Enhance Access to Oral Health Care Services for MCH Populations - Collaborate with statewide partners to identify and address gaps in the oral health service delivery system; conduct oral health surveillance to inform the oral health systems enhancement initiatives; support the training and placement of oral health professionals in underserved areas to better meet the oral health needs of MCH populations; encourage the integration of oral health preventive services into primary care and school health settings.

MCH priorities no longer include:

-Reduction of Child Abuse and Neglect

-Enhance Environmental Supports and Policy Planning/Development for the Prevention of Chronic Disease (this priority is an integral part of the preconception priority)

MCH priorities that emerged for the first time in the 2010 MCH Needs Assessment:

-Reduction of Teen Pregnancies and Births

-Improvement of Preconception Health Among Women of Childbearing Age

These priorities establish a framework for the allocation of Title V MCH Block Grant resources over the next five years. While the importance of life course perspective is evident across all priorities, the overriding MCH priority need that emerged based upon data analysis, focus groups results, MCH stakeholders meeting and Missouri Title V programs was to improve access to care for MCH population groups in Missouri. Improved access to MCH services will require a much larger commitment of State resources beyond Title V MCH Block Grant funding.

/2012/As part of Missouri's efforts to continually assess the maternal and child populations; various workgroups, advisory committees and steering teams meet on a regular basis and are described in more detail throughout this application.

A Home Visiting Needs Assessment, separate from the 2010 Title V MCH Needs Assessment was completed as part of the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. A series of focus groups were conducted as part of the home visiting needs assessment. This assessment lead to ranking all counties in Missouri based on a composite score of each county's ranking on thirteen key risk indicators.

/2013/The Home Visiting Needs Assessment completed on behalf of the ACA Maternal

Infant and Early Childhood Home Visiting program identified the following top ten communities (counties) of highest risk: Pemiscot, Dunklin, Butler, Ripley, St. Louis City, Mississippi, New Madrid, Washington, Crawford and Scott counties.//2013//

The Pediatric Nutrition Surveillance System (PedNSS) and Pregnancy Nutrition Surveillance System (PNSS), WIC surveillance systems will be discontinued starting in 2012. Missouri will continue WIC data dissemination through the WIC Missouri Information for Community Assessment (MICA) portal.

A 26 page summary document was created from the original 5-year Needs Assessment and was distributed with the FFY 2012 MCH Application request for public comment. The MCH Needs Assessment Summary was e-mailed to 388 various public contacts including council members, community partners, Local Public Health Agencies (LPHAs), health care professionals, and industry leaders; posted on the Department of Health and Senior Services' web site; and is included as an attachment to this section.//2012//

An attachment is included in this section. IIC - Needs Assessment Summary

/2013/Missouri's benchmark plan and the associated performance measures for the respective constructs for the State Maternal Infant and Early Childhood Home Visiting (MIECHV) Program has been approved by the granting agency and program implementation has begun.

Missouri's WIC program along with other states is actively participating in the CDC's webinars on PedNSS and PNSS knowledge and technology transfer and is in the process of compiling a list of indicators for Missouri WIC MICA.//2013//

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

The Title V Maternal and Child Health (MCH) Agency in Missouri is the Department of Health and Senior Services (DHSS), Division of Community and Public Health (DCPH), Section for Healthy Families and Youth (HFY). The Section Administrator, Melinda Sanders, MSN, RN, serves as the Title V Director. Two principal bureaus for serving the MCH population are located within the section; Genetics and Healthy Childhood (GHC) and Special Health Care Needs (SHCN).

/2012/Melinda Sanders remains the Title V Director, but now serves in the capacity as Deputy Director for the DCPH. The DCPH is currently being restructured and future details of the new organization structure can be found in Section III. State Overview, C. Organizational Structure.//2012//

Title V related activities throughout DHSS support Missouri's health care delivery system across each of the four levels of the MCH pyramid (direct services, enabling services, population-based services and infrastructure building activities) are detailed further throughout this application (see the attached Missouri Core Pyramid of Services).

Following is a brief description of some physical, economic, and legislative areas which impact the health and well-being of the maternal and child populations.

/2013/A current organizational chart for the Department is included in the attachments.//2013//

Geography

Missouri is comprised of 115 counties\independent city covering an area of 69,709 square miles and ranks 21st in size among all states in the nation. The state is centrally located in the heartland of the United States and shares borders with Arkansas, Kansas, Kentucky, Illinois, Iowa, Nebraska, Oklahoma, and Tennessee. The two largest rivers in the state are the Mississippi, which marks the eastern border of the state, and the Missouri, which flows across the middle of the state. Two large metro areas, Kansas City and St. Louis are located on the western and eastern borders respectively and are connected by the "I-70 Corridor".

Demographics

In 2008, Missouri had a total population of 5.9 million and was ranked as the 18th largest state. From 2000 to 2008 the state's overall population increased by 5.6%. Those ages 65 and over, currently make up 13.6% of the state's total population. In the next several years, the 65 and over population is expected to increase to over 20%.

Missouri residents are predominately white (85.8%) with a significant African-American (11.9%) and a smaller Asian/Pacific Islander (1.7%) and American Indian (0.6%) population. Over 80% of Missouri's African-American population is located in the three largest counties (St. Louis City, St. Louis County, and Jackson County-Kansas City area). Hispanics represent a small but growing segment of the population, which is more broadly dispersed throughout the state and makes-up only 3.2% of the total population. Latino is the fastest growing sub-population in the state and has increased by 60% from 2000 to 2008. In 2008, Missouri's estimated MCH population including women of childbearing age (15-44), infants, children, and adolescents (1-19) was 2,566,154. This accounted for nearly half (43.4%) of the state population and showed a slight decrease of 1.1% from 1999.

Missouri's population reflects a dichotomy between its largest metropolitan statistical areas (MSA) (St. Louis on the east and Kansas City on the west) and its more rural areas. Missouri has 34

counties designated as MSAs. Over half of the state's population (55%) resides in the St. Louis and Kansas City MSAs. The St. Louis MSA, which includes St. Louis City, St. Louis County and six other counties, accounts for over one-third of the total state population. The Kansas City MSA, including Jackson County and eight other surrounding counties, accounts for nearly 20%. Missouri has 24 counties designated as micropolitan statistical areas. About half (57) of Missouri's counties (115) are not designated as either metropolitan or micropolitan areas.

Over the past few decades the majority of population growth occurred in the suburban areas of Kansas City and St. Louis and in the more rural central and southwestern parts of Missouri. The population has either decreased or remained static in the urban cores of Kansas City and St. Louis, as well as the largely agricultural lands of northern and southeast Missouri.

According to the 2008 American Community Survey (ACS), 306,405 (5.6%) Missourians age five and above are estimated to speak a language other than English at home. Of that group, 125,855 persons (2.3% of the total Missouri population) speak English less than 'very well'. An estimated 138,268 (2.5%) Missourians use Spanish as the primary home language.

/2012/From 2008 to 2009 the state's estimated population has increased by 0.5% while the Latino sub-population grew by 4.3%.

The 2009 American Community Survey (ACS) showed an increase over 2008 of 17,363 (5.67%) Missourians age five and above who are estimated to speak a language other than English at home. In addition, the 2009 ACS also showed an increase over 2008 in the estimated number of Missourians who use Spanish as the primary home language by 8,525 (6.17%).//2012//

/2013/From 2009 to 2010 the state's estimated population has increased by 0.5% while the Latino sub-population grew by 4.2%.

According to the 2010 American Community Survey (ACS), 341,861 (6.1%) Missourians age five and above are estimated to speak a language other than English at home. Of that group, 129,002 persons (2.3% of the total Missouri population) speak English less than 'very well'. An estimated 144,142 (2.6%) Missourians use Spanish as the primary home language.//2013//

Economy

Missouri's metropolitan areas make up the largest portion of the state's economy. St. Louis County and Jackson County combined contribute nearly one third of the state's economy in terms of employment, personal income, and population. Despite the size, all of the regions have a role in the state's economic makeup. Missouri's rural areas are especially important to tourism and agriculture in the state. Much like the nation, Missouri's economy has experienced a downturn in the past few years. This trend can be seen in slumping manufacturing exports as the automotive and other industries have struggled.

Unemployment has also increased substantially. The unemployment rate rose from 5.8% in May 2008 to 9% in May 2009. The education and health services sectors had the largest growth between 2007 and 2008 with an increase of 5,900 jobs. The federal and local government sectors have also increased employment over the year. Manufacturing employment has been trending downward with declining employment in the housing and auto industries.

In 2008, 13.3% of Missouri's population had incomes below the federal poverty level. Missouri's poverty rate increased faster than the national average between 2001 and 2008 (11.7% to 13.2% for the US; 9.7% to 13.3% for MO). Between 1999 and 2008, the median household income in Missouri dropped by 14.6%, the steepest decline among all 50 states. The national decline in median household income was 2.5%. Missouri's decline was nearly six times faster than the national average. In FY2000, half of the households in Missouri had an income of more than

$54,930. In FY2008, the midpoint was $46,906. Only to compound the issue, the U.S. Bureau of Labor Statistics calculates that a dollar in 2008 had the same buying power as 77 cents in 1999. Thus the median Missouri household in 2008 had 34% less buying power than it did nine years earlier. The median household income figures were compiled from Census Bureau data by the Robert Wood Johnson Foundation as part of the report "Barely Hanging On: Middle Class and Uninsured". The report showed that the rising costs of health care had a great deal to do with the loss of household purchasing power for the middle class. More than one in 10 of all Missourians covered by employer-sponsored health insurance lost that coverage in the study period.

For the 12 months ending September 2009, there were 378 St. Louis business bankruptcies. This was up nearly 19% from the year before and nearly 25 times the number of filings two years prior. The St. Louis trend is reflected in other parts of the state.

/2012/Unemployment rates decreased from 10.5% in February 2010 to 9.9% in February 2011, but remain high by historic standards. Manufacturing employment saw a decrease of 4,800 jobs (1.9%) from May 2009 to May 2010. However, manufacturing employment began to stabilize in early 2010 both in Missouri and the nation.

In 2009, 15.5% of Missouri's population had incomes below the federal poverty level compared to 14.3% nationally. Missouri's median household income was $45,229 in 2009 according to the American Community Survey's estimates. This was lower than the US figure of $50,221. Overall, Missouri ranked 35th in household income in the nation. Both Missouri and the US had slight decreases in median household income from 2008 to 2009 (2008: US-$52,029; MO-$46,867).//2012//

/2013/Unemployment rates decreased from 9.2% in December 2010 to 7.7% in December 2011 (not seasonally adjusted).

In 2010,15.3% of Missouri's population had incomes below the federal poverty level, similar to the national level (15.3%). Missouri's median household income was $44,301 in 2010 according to the American Community Survey's estimates. This was lower than the US figure of $50,046.Overall Missouri ranked 38th in the nation in household income.//2013//

Homelessness

Homelessness is a problem for both rural and urban Missouri. In 2006, an estimated 5,067 rural Missourians were homeless. Nine hundred fifty-nine were categorized as victims of domestic violence, substance abuse, or those with mental illness. Missouri was ranked 41st in the nation for the number of homeless children in 2005-2006. Of the 256,000 children living in poverty, an estimated 12% are homeless. In 2005-2006, an estimated 30,478 children were homeless throughout the state. Of those, an estimated 12,801 were under 6 years old.

/2012/Missouri had an estimated 1,031 homeless families on a single night in 2009, with providers serving more than three times their bed capacity over the course of the year.//2012//

/2013/From 2009 to 2010 the estimated total homeless population in Missouri increased by 1,163 (16.7%). The overall 2010 rate of homelessness was 0.12%. Missouri was ranked 33rd in the nation for extent of child homelessness in 2010.//2013//

Transportation

Missouri's transportation system was ranked 6th best in the nation in 2009. It has 3 key transportation measures: railroad mileage, waterway mileage, and airports. With the nation's 7th largest highway system, the high quality of Missouri's infrastructure gives Missouri businesses efficient accessibility to major markets for distribution needs and telecommunication. Access to

public transportation is limited in the rural areas. There are few mobility options for residents without access to automobiles.

/2013/Missouri's transportation system ranked 9th best in the nation in 2011. The high quality of Missouri's infrastructure gives Missouri businesses an edge over the competition, insuring efficient accessibility to major markets for all their distribution and telecommunication needs.//2013//

Health Care Coverage

In 2008, an estimated 6.8% of children (under 18) and 16.3% of women (ages 18-44) were without health insurance in Missouri. The estimated percentage of employment-based health insurance in Missouri decreased from 71% in 2002 to 64% in 2008 for children and was essentially unchanged for women (65% vs. 66%). The percentage of children under 18 without health insurance in Missouri has been consistently lower than that of the nation (6.8% vs. 9.9% in 2008), and has steadily increased from 4.7% in 2001 to 10.5% in 2007, but decreased to 6.8% in 2008.

Medicaid covers 34% of Missouri's children and pays for about 47% of all births in the state. Children represent the largest demographic group served by Missouri Medicaid, with 58% of all Medicaid enrollees being age 18 or younger. Approximately 26% of Missouri's total budget went to Medicaid in State Fiscal Year (SFY) 2009.

The Medicaid program in Missouri provides health insurance coverage for children under age 19 whose net family income does not exceed: 185% of Federal Poverty Level (FPL) for children under age 1, 133% of FPL for children ages 1-5, and 100% of FPL for youth ages 6-18. Approximately 547,254 low-income Missouri children have health insurance coverage through this program.

Using the State Children's Health Insurance Program (SCHIP) funds, Missouri expanded its existing Medicaid program for low-income children in 1998. This SCHIP expansion extended health coverage to low-income children with family income up to 300% of FPL. The SCHIP program provides the same health services as those covered under Medicaid, except that children covered by SCHIP are not eligible for non-emergency medical transportation. Based on an income scale, some individuals covered under Missouri's SCHIP program must pay premiums. Premiums paid per family per month range from $12 to $300. Approximately 118,591 children have coverage under the SCHIP program in Missouri. This number represents 7% of the total Medicaid population.

Pregnant women with family incomes up to 185% of FPL qualify for Medicaid coverage. Qualification under this category includes 60-day postpartum coverage even with subsequent increases in family income. Approximately 27,000 women received insurance benefits under this program during SFY 2008. This group represents 3% of all Medicaid recipients in the state.

Medicaid provides access to services through either the fee-for-service system or the managed care system. In Missouri, all individuals eligible under Medicaid for the Aged, Blind, and Disabled program participate in the fee-for-service system regardless of their county of residence. Additionally, children and parents that live in counties other than those designated as managed care counties participate in the fee-for-service system.

The Medicaid managed care system started in 1995. Effective January 1, 2008, Missouri's Medicaid Managed Care program expanded into 17 additional counties. The managed care system now operates in a total of 54 counties across the state. These counties are located along the "I-70 Corridor". All Medicaid recipients must enroll in a managed care health plan if they reside in one of the 54 counties included in the managed care system and if they fit into one of the following eligibility categories: parents/caretakers, children, pregnant women, and refugees;

other Medicaid children who are in the care and custody of the state and receive adoption subsidy assistance; and children covered by SCHIP. Approximately 380,000 Missourians were enrolled in one of the six contracted Medicaid Managed Care Plans as of June 2008.

Managed care programs work on various Performance Improvement Projects throughout the year. This year some of the areas of focus have been asthma, ER use, immunization (free transportation and outreach at community events), lead (community events and letters to parents), adolescent health, EPSDT screens, hi-risk OB care, dental care, and one plan worked on a Medical Home project. More specific details on several of these activities can be found in the applicable performance measures.

/2012/The estimated number without health insurance has shown a significant increase from 2008 to 2009, for children under age 18 (6.8% to 9.7%) and for women ages 18-44 (16.3% to 22.4%). The estimated percentage of employment-based health insurance in Missouri decreased from 64% in 2008 to 59% in 2009 for children and from 66% to 58.5% for 18-44 year old women. The percentage of children under 18 without health insurance in Missouri has been consistently lower than that of the nation but that gap has been shrinking (9.7% vs. 10.0% in 2009).//2012//

/2013/In Missouri, an estimated 8.9% of children (under 18) and 21.8% of women (ages 18-44) were without health insurance in 2010. The percentage of children covered by employment-based health insurance decreased from 71% in 2002 to 60.1% in 2010 and for women ages 18-44 decreased from 65% to 58.5%. The percentage of children under 18 without health insurance in Missouri has been consistently lower than that of the nation (8.9% vs 9.8%) in 2010.//2013//

Environment

Lead mining and smelting is an important part of Missouri's history. Missouri became the dominant lead-producing state in the nation in 1907. It has remained number one ever since. The most common sources of lead poisoning are lead dust; lead in soil; and peeling, chipping or cracking lead based paint. Lead-based paint was banned from residential use nationwide in 1978. Any home built before 1978 may contain leaded paint. The highest risk of lead exposure for children is found in homes built before 1950, when most paint contained a high percentage of lead. More than 23.6% of the housing stock in Missouri was built before 1950. Sixty counties in Missouri have greater than 23.6% pre-1950 housing stock.

The number of Missouri's children younger than six years old who have been tested for lead exposure annually has increased from 50,362 in 2000 to 93,739 in 2009. Of the number of children tested, the percentage found to have elevated blood lead levels has declined from 11.1% in 2000 to 1.1% in 2009. This decrease mirrors a nationwide decrease in children's blood lead levels. In 2009, of the 93,739 children in Missouri who received a blood lead test, 1,071 (1.1%) had a blood lead level of 10 µg/dL or greater.

The Childhood Lead Poisoning Prevention Program (CLPPP) within the Division of Community and Public Health (DCPH) is a Centers for Disease Control and Prevention (CDC) funded program. The Missouri program was established in 1993. The program's mission is to assure the children of Missouri a safe and healthy environment through primary prevention, detection, surveillance and case management for lead exposures that may cause illness or death. Passed in 2001, RSMo 710 required DHSS to promulgate rules and regulations to establish a statewide screening plan. The rules and regulations define criteria for establishing geographic areas in the state considered to be at higher risk for lead poisoning; outline blood lead testing requirements and protocols; and define lead testing follow-up and treatment procedures. In developing these regulations, CLPPP applied Missouri surveillance and census data to establish criteria for Universal Testing (high-risk) areas in Missouri.

/2012/Natural Disasters

"First a tornado tore through the St. Louis airport. Then rising waters swamped small towns and flooded miles of fertile farmland along the Mississippi River. Then the nation's deadliest tornado in six decades ripped apart the city of Joplin.

Thirty days of destruction in Missouri. Billions of dollars of damage. And it may not be done, as communities along the Missouri River from St. Joseph to St. Louis brace for a new round of flooding." from a June 5, 2011 Associated Press news story Disastrous Spring Costing Missouri Billions of Dollars by David A. Lieb

On April 22, Good Friday brought an EF-4 tornado to St. Louis with winds topping out at 165 miles per hour. The National Weather Service confirmed four tornadoes in the area with Lambert Airport sustaining severe damage. At least 120 homes were destroyed and 750 damaged, but miraculously there were no fatalities and only minimal injuries.

Parts of southeastern Missouri received over 15" of rain within a 4 day period. During the next couple of weeks, as many as 200 miles of roads had been flooded and farmers had lost between $150 million and $400 million in crops. In an effort to protect cities downstream, the Army Corps of Engineers blew open the Birds Point levee in Mississippi County to relieve flooding pressure on nearby Cairo, Ill. The 130,000-acre floodway contains about 100 homes and some of the most prime farmland in the state.

At 5:41 p.m. on May 22, a three-quarter of a mile wide tornado touched down in Joplin. The tornado tracked on the ground for approximately six miles. There were more than 150 fatalities and more than 5,000 structures were estimated to be heavily damaged or destroyed.

The Governor of Missouri issued a state of emergency on April 22, 2011 and extended the expiration date of that executive order until September 15, 2011. Since Governor Nixon's request for a major disaster declaration from the Federal Government on May 9, 2011, President Barack Obama has granted individual assistance designation for 22 counties and public assistance designation for 38 counties in Missouri.

While the overall priority needs for Missouri's maternal and child health populations have not changed since the previous needs assessment, several areas of the state are having to focus on the more immediate needs of food, shelter and clothing and will be faced with a more long-term economic need.//2012//

/2013/The City of Joplin has had a tremendous year of growth this past year. Having cleared the debris and issued over $310 million in building permits, including 600 permits for new homes and 3,000 for residential repairs and rebuilding projects. The city is proud to report that 80% of businesses have reopened, including retail chain and small businesses. The devastated St. John's Regional Medical Center is in the process of being rebuilt as the new Mercy Hospital Joplin. The success of this community's recovery has been attributed to the city leadership's collaborative efforts with the business community, a school system determined to getting children back into the classrooms as soon as possible, and citizens who gave up their day jobs to manage and administer the community's rebuilding efforts. The spirit and pride of the Joplin citizens has definitely helped them to achieve a remarkable recovery. As a result of this disaster, a portion of the MIECHV grant funds are being used to provide Early Head Start Home Based Option to Joplin area.//2013//

Major Legislative Initiatives

2009 Missouri Legislative Session

HB 716 was passed which was enacted as RSMo 191.711.1. The legislation required the DHSS

to prepare written educational publications with information about possible complications, proper care and support associated with premature infants; to distribute the materials to children's health and maternal care providers, hospitals, public health departments, and medical organizations; and to encourage those organizations to provide the publications to parents or guardians of premature infants.

The Department's Bureau of Genetics and Healthy Childhood worked collaboratively with birthing and children's hospitals that have neonatal intensive care units to evaluate educational materials currently in use and to determine which materials would be best to use on a statewide basis. Medimmune, the maker of Synagis, the vaccine indicated for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV), had been instrumental in getting this legislation passed in Missouri and some other states. Medimmune offered the Department educational materials they had developed to educate parents of premature infants on a variety of topics. After reviewing their materials a decision was made to use six of their handouts and to include three provided by the Department, which included a Resource List for Parents of Premature Infants, a brochure on "Baby Blues," and a Car Seat Safety Card for Premature Infants. All of these materials are posted on the Department's website.

Legislation was passed that expanded the newborn screening (NBS) panel to include testing for five lysosomal storage disorders (LSD's): Krabbe disease, Gaucher's disease, Niemann-Pick disease, Pompe disease, and Fabry's disease. These disorders are to be added to the NBS panel by July 1, 2012. The Newborn Screening Program anticipates that a pilot program will start in late 2011. Missouri will be the first of two states to screen for five of the LSDs at once and when implemented will be a leading state in the nation for newborn screening. Additional lysosomal disorders (over 35 of them) can be added as technology allows.

2010 Missouri Legislative\Budget Session

The 2010 Legislative Session in Missouri closed without passage of a number of bills considered to be "key" in addressing the state's budget situation and a number of the Governor's priorities. In total, 118 pieces of legislation were truly agreed to and finally passed in this session, and some of the successful bills are as follows:

HB1764 creates a referendum that puts the new federal health insurance mandate to a vote of Missouri residents on the August 3, 2010 ballot. Voters will decide whether the people and employers of the state can/cannot be compelled to have health insurance. The legal impact of the state measure is questionable, because courts generally have held that federal laws supersede state laws.

HB1270 changes the name of the Crippled Children's Services to Children's Special Health Care Needs Service. This piece of legislation has been proposed numerous times in the past 12 years and we are very happy that it was successful this year.

HB1311 & 1341 mandate insurance coverage for individuals with autism spectrum disorders. This bill also prohibits a carrier from denying or refusing to issue insurance coverage on, refusing to contract with, refusing to renew or reissue coverage on, or terminating or restricting coverage on an individual or his or her dependent because the individual is diagnosed with Autism Spectrum Disorder (ASD). In addition, this bill requires insurance carriers to pay for applied behavior analysis for individuals younger than 19 with a maximum benefit of $40,000 per year, adjusted annually.

HB1375 allows expedited partner therapy. This bill allows a licensed physician to use expedited partner therapy under certain conditions by dispensing and prescribing medications for the partner of a person diagnosed with certain sexually transmitted diseases even when there is no existing physician/patient relationship.

HB1472 adds 1-pentyl-3-(1-naphthoyl) indole, commonly known as K2 as a Schedule I controlled substance. This substance has been popular especially among adolescents as it has been available without any restrictions and provides users a "marijuana-type" effect.

HB1695 strengthens reporting designed to better identify repeat offenders, provides greater accountability and transparency for court actions, enhances the use of DWI courts and includes language helpful to enforce actions. This bill was signed by the Governor on June 4, 2010 and becomes law on August 28, 2010.

HB2270 allows child abuse medical resource centers and providers receiving training from the Sexual Assault Forensic Examination-Child Abuse Resource Education (SAFE-CARE) network to collaborate directly or through the use of technology to promote improved services to children who are suspected victims of abuse and need a forensic medical examination by providing specialized training for forensic medical evaluations in a hospital, child advocacy center, or by a private health care professional without the need for a collaborative agreement between the child abuse medical resource center and a SAFE-CARE provider.

SB793 expands the information required to be provided to women 24 hours before abortions, including the option of viewing an ultrasound and listening to a heartbeat of the fetus.

Some of the bills failing to pass this year include:

Reducing the benefits of state employees - fewer state holidays and requiring new employees to contribute 4% of their pay to the retirement system and they would not have been eligible for retirement until later than allowed under current law.

Several measures sought to ban all Missouri drivers from sending cell phone text messages while driving. Currently, only persons 21 years of age and younger are banned from texting while driving.

Various proposals would have created new tax incentives for manufacturers that retain jobs by improving their factories; granted Missouri businesses an edge in getting existing tax incentives; and used a portion of the taxes from technology companies to recruit other such firms.

Gov. Jay Nixon, Senators, and House Democrats pushed for new limits on state tax credits, but House Republicans refused to consider the reductions.

People receiving state cash assistance would have been required to pass drug tests or lose benefits, and elected state officials would have faced a similar requirement.

Perhaps the most significant pieces of legislation that resulted from the 2010 Legislative Session was the state budget for the FY2011 fiscal year which begins on July 1, 2010. It is anticipated the state budget for FY2010 will end $1.5 billion less than revenues. As a result, the Governor has with-held current year funds from virtually every Department in state government. Medicaid reimbursement rates have been reduced, the Parents as Teachers program has been reduced, vacant state employee positions have been "held", and programs anticipating a lapse in funding have been "swept". In addition, the Governor announced the budget sent to him by the General Assembly for FY2011 is predicted to be $350 million short. Thus, all Departments once again are anticipating with-holdings of funds at the start of the next fiscal year. The Department of Health and Senior Services, Division of Community and Public Health finds ourselves in an even more precarious position-the Division's budget for FY2011 was not finalized by the General Assembly. It is anticipated that the Governor will communicate both with-holds and finalization of the Division's budget closer to July 1, 2010. The Division does anticipate state employees will be required to be laid-off, but the exact numbers are unknown at this time.

/2012/Due to budget constraints funding for School Health contracts was eliminated beginning

July 1, 2010.

2011 Missouri Legislative\Budget Session

Missouri's 2011 General Assembly was comprised of a record number of freshman Legislators. In the end, a much smaller number of bills were actually truly agreed and finally passed as compared to previous Legislative Sessions. The following is a listing of bills of interest to the MCH population:

Abortion: Bans abortions after 20 weeks of gestation except in the case of a medical emergency or when the fetus is no longer considered viable.

Concealed Guns: Lowers the minimum age to obtain a concealed-gun permit to 21 from 23 years of age.

Drug Tests: Requires welfare recipients suspected of using illegal drugs to undergo drug testing.

Synthetic Drugs: Bans "bath salts" and expands the ban on K2, synthetic marijuana.

Domestic Violence: Revises the law on orders of protection and extends the address confidentiality program for stalking victims.

Sexual Abuse: Requires school districts to inform other districts if a teacher is fired or forced to resign for sexually abusing a student.

Umbilical Cord Blood: Requires the Department of Health and Senior Services to post on its website resources relating to umbilical cord blood.

High School Sports Concussion: Establishes the Interscholastic Youth Sports Brain Injury Prevention Act which requires the Department Health and Senior Services to work with school boards, the Missouri State High School Activities Association and a Brain Injury support services provider to develop guidelines regarding head injuries. In addition, youth sustaining a concussion or brain injury in practice or game shall be removed from play for at least 24 hours. The youth must be evaluated by a licensed health care provider trained in the evaluation and management of concussions.

/2013/The legislation establishing the Interscholastic Youth Sports Brain Injury Prevention Act was passed, rules have been formulated and are in the review process.//2013//

Bicycling and Walking: The House of Representatives went on record to support the "Complete Streets" or "Livable Streets" concept meaning roads, streets and communities are constructed in such a way that all road users (pedestrians, bicyclists, disabled persons, automobiles, trucks, buses, and public transportation) feel safe, secure and welcome in the use of the roadway.

/2013/The Livable Streets (LS) project sought to increase access to adequate bicycling and walking facilities through a twofold approach.

•First, the project collaborated with MODOT to develop a design manual for use by communities in the planning and design of LS. Components of this manual will be incorporated into MODOT's online Engineering Policy Guide that directs communities on how to design and build transportation facilities that are supported by MODOT funds.
•Second, the project focused on educating citizens and transportation professionals to increase their awareness of and demand for LS projects. Key components included the creation of an Advocacy Manual, community advocacy trainings, and a media campaign. Education was provided to transportation engineers and planners through a statewide televised workshop and presentations at key professional organization conferences.

The collaboration between the Missouri Livable Streets project, MODOT, advocates, and other stakeholders resulted in several strategic successes including:

•Increased citizens' awareness of LS elements and advocacy concepts. 11 trainings were held in different communities. 279 people attended training with the majority of evaluation respondents stating that they were much more or slightly more aware of Livable Street topics after the workshop. After attending workshops participants spoke with family and friends about LS, attended a local coalition meeting, promoted LS, met with local officials, or started a local coalition or advocacy group. The impact of citizens' efforts to promote livable streets in their communities included:

•14 community bicycle/pedestrian plans were initiated or developed
•7 communities sought funding to support livable streets projects
•5 communities adopted livable streets policies or ordinances
•4 communities were working on livable streets policies
•2 communities implemented livable streets policies or ordinances

•Increased communication channels for Missouri Livable Streets. Through the media project, it is estimated that Missouri Livable Streets messages have reached 465,587 people.
•Increased local engineer and planning professionals' knowledge in bicycle-pedestrian design. 954 professionals received some type of training on Livable Street design.
•Passage of a complete streets resolution by the state legislature.
•Increase in the number of municipalities that have passed LS policies or ordinances. Provided technical assistance in 25 communities, reaching over 581,090 residents.//2013//

HB273 and HB460 were introduced to require schools to lay out more details in their bullying policies.//2012//

/2013/2012 Missouri Legislative\Budget Session

The 2012 session of the Missouri General Assembly ended with few major pieces of successful legislation. Perhaps the most important of which is the FY13 Missouri state budget. Again this year, further reductions were necessary in order to balance the state budget. Reductions impacting the MCH community are as follows: $66,130 in chronic disease prevention/management; $4 million to Missouri's Public Health Services funds were diverted from newborn screening & follow-up, lead testing, vital records, laboratory testing for sexually transmitted diseases & TB to fund local public health departments. In addition, HB 1731 passed which removed $11.5 million from the Early Childhood Development Education and Care programs and specifically states, "No public institution of higher education, political subdivision, governmental entity, or quasi-governmental entity receiving state funds shall operate, establish, or maintain, offer incentives to participate in, or mandate participation in a quality rating system for early childhood education, a training quality assurance system, any successor system, or any substantially similar system for early childhood education, unless the authority to operate, establish, or maintain such a system is enacted into law...".

Other bills that passed impacting the MCH population include: tighter restrictions on unlicensed child care centers which would allow a judge to bar unlicensed providers who have been charged in the abuse, neglect or death of a child from providing services until their case is resolved; allowing employers to refuse to provide health insurance that covers contraception, sterilization or abortion based on religious exemption; authorizing conversion of several thousand traditional billboards along MO highways to digital formats; and increasing funding for autism services by $750,000.

Bills that did not pass during the 2012 session include: creation of a state-run database to track prescriptions for certain medicines (especially narcotics); voter photo identification requirement; removal of some crimes from the mandatory sex offender registry; and banning employer discrimination due to gun ownership. HB1900, which required the Department of Health and Senior Services to apply for a Medicaid waiver for persons with brain injuries, was passed by the General Assembly but vetoed by the Governor sighting a "Hammerschmidt" issue. In 1994, the MO Supreme Court found a violation of the constitutional rule against introduction and passage of bills containing more than one single subject.//2013//

Challenges to the Delivery of Title V Services

The impact of a declining economy can be felt across various U.S. public and private sectors, including public health, and MCH is no exception. With declining revenues, states are forced to cut/reduce services and staff that are critical to run MCH programs. Missouri is no different than the rest of the nation and is facing the brunt of a poor economy and lack luster job market. MCH priority needs will be competing for funds with a growing host of other state priorities resulting from the state budget shortfall and reductions. In addition, the number of individuals qualifying for services will increase as the economy and job market decline.

According to the Robert Wood Johnson Foundation report "Shortchanging America's Health" in FY 2008-2009 Missouri spent just $9.26 per resident in State funds for public health. Of the 50 states and the District of Columbia, only one state spent less. The national median average was $28.92 per capita.

Along with a shortage of primary care providers, there are geographic, insurance, transportation, and other structural barriers to the access of primary medical care. Of the 115 counties in Missouri, 100 are currently designated health professional shortage areas (HPSA). Further, Missouri's increasingly diverse cultures, struggling economies and limited financial and human resources influence efforts to address disparities and the quality of health care services.

The delivery of oral health education, prevention, and treatment continues to be a challenge. One barrier is a shortage and maldistribution of dentist. For instance, 2010 licensure data indicates 3,327 dentists are licensed in Missouri, however only 2,437 are actively practicing in the state, with the majority located in metropolitan areas. Further, very few dentists accept Medicaid as evidenced by 2009 Medicaid claim data, which indicates 234 (9%) of dentists were enrolled as Medicaid providers. Of the 234 Medicaid dentists, 67 (28.6%) had one or more Medicaid claims in 2009. This leaves the vast majority of the approximately 500,000 children enrolled in Medicaid without a dental home.

Barriers to delivering oral health related education and services include the lack of understanding and buy-in regarding the impact of oral health on overall health; such as the management of diabetes, cardiovascular disease, and improving maternal and infant health outcomes. Missouri's oral health program does not receive general revenue funding and relies solely on Title V funding to sustain programming.

Public transportation is limited in most of the rural areas of Missouri. Although Medicaid provides transportation to scheduled medical appointments for Medicaid eligible individuals, those services are only available with three days notice. Therefore, many low income women and children have limited access to transportation to medical appointments of a more immediate nature.

In addition, a challenge to both medical and dental primary care is health literacy. Often vulnerable populations do not possess adequate health literacy skills to implement recommended action steps; this is overlooked by many health professionals and their staff that may be providing information.

Changes to the MCH Services contracts with Local Public Health Agencies (LPHAs) involve shifting from service delivery to working with community partners for systems building and sustainability in addressing MCH priority health issues. Examples of challenges for urban MCH contractors addressing obesity prevention are the lack of access to affordable fresh produce and safe environments for physical activity. Rural communities lack sidewalks and very often lack the resources available in urban areas.

The Public Health Burden Report of Traumatic Brain Injuries in Missouri completed in March 2007 identified children ages 0-4 years as being one of two populations with the highest rates of hospitalization and emergency room visits for traumatic brain injury (TBI) in Missouri. Children acquiring a TBI in early childhood live with the effects of TBI their entire life. The Missouri 2004 TBI Needs and Resource Assessment identified limited public knowledge of TBI as being a major barrier to services for the preschool population.

/2013/The CCHC Program offers topical trainings regarding health and safety to child care facility staff and incorporates inclusion of children with special health care needs throughout.

MCH Services contractors (LPHAs) addressing injury, obesity and tobacco prevention are facing more challenges working collaboratively with community partners due to the decreased staff and hours of operation as a result of public health funding cuts.//2013//

/2013/The revisions to the CCHC contract allow more opportunity for the LPHAs to bill for consultations with child care providers that are not face to face, but through other communication such as emails and phone calls that are provider initiated.//2013//

/2013/A Revenue Maximization Proposal was submitted by the MO Medicaid Agency to the Centers for Medicare and Medicaid Services on June 28, 2012.//2013//

Department Priorities and Initiatives

The activities of the Missouri Department of Health and Senior Services (DHSS) are focused around four main goals listed in the DHSS Strategic Plan 2010.

1. Increase Commitment to and Investment in Health
2. Improve Health and Health Care Delivery
3. Ensure that Our Consumers are Safe and Healthy
4. Achieve Optimal Productivity, Efficiency and Effectiveness.

Every five years, as part of the MCH Block Grant a statewide needs assessment is conducted. State MCH Priority Needs and Performance Measures are revised based upon this assessment. In 2009/2010, focus groups met in 13 locations around the state. In addition, a maternal and child health statewide stakeholders meeting was conducted in April 2010. Based on the needs assessment process, Missouri has identified the top ten state MCH priorities which will be the focus of the next five years. Woven throughout these priorities is an overarching life course perspective. Many of the state performance measures have been revised in an attempt to incorporate the interplay of early life events on later health.

Missouri's 2010 MCH State Priorities are:

1. Improve health care access for MCH populations
2. Prevent and reduce smoking among women and adolescents
3. Reduce obesity among women, children and adolescents
4. Improve the mental health status of MCH populations
5. Enhance access to oral health care services for MCH populations
6. Improve preconception health among women of childbearing age

7. Reduce the rate of teen pregnancies and births
8. Reduce disparities in adverse birth and pregnancy outcomes
9. Reduce intentional and unintentional injuries among women, children and adolescents
10. Support adequate early childhood development and education

Each year, as a part of the MCH Grant process, proposed requests for the use of MCH funds are submitted to the Title V Director. The requests are evaluated based on the MCH State Priorities and on a weighted score for each of the nine factors listed below.

1. Size of the problem (population affected)
2. Seriousness of the problem (morbidity/mortality)
3. Availability of interventions
4. Effectiveness of interventions
5. Economic feasibility
6. Community perception of the problem
7. Acceptability of the intervention to the public
8. Political issues related to the problem
9. Propriety/scope of responsibilities (public health role)

Information from the process above is used by the Title V Director, Division of Community and Public Health Director's Office and the Department of Health and Senior Services Director's Office to prioritize the use of Title V funds in the state.

/2013/MCH Contracts/LPHA Priority Areas//2013//

/2013/The LPHA contracts for FFY 12-14 include focus areas and system outcomes. During the first year of the contract LPHAs are primarily assessing their communities on policies & services available. With work plans based on the Spectrum of Prevention framework, LPHAs have developed plans with a system outcome(s) for each of the six levels to reach by the end of the contract period (9/30/14) and activities for each level per year that work toward those system outcomes.

The Center for Local Public Health Services has 115 contracts with county and city health departments in MO. Each contractor is required to evaluate the needs of their community and select one priority area from the four options (injury, obesity, and tobacco prevention or the prevention of adverse birth outcomes). While the MCH contract provides funding for a variety of efforts pertinent to this population, the priority area is to be an area which the county focuses their efforts for a minimum of four years. Currently 51 LPHAs are focused on prevention and reduction of obesity among children, adolescents and women; 12 are focused on prevention and reduction of smoking among adolescents and women; 43 are focused on the prevention and reduction of intentional and unintentional injuries; and 9 are focused on the prevention and reduction of adverse birth outcomes. The following are some examples of the activities associated with each of these priority areas.

Injury Prevention:
Several counties are focused on motor vehicle safety including: addressing risky driving/passenger safety practices (speeding, seat belts, distracted and/or impaired drivers); safe sleep for infants, and injury prevention in child care settings; bullying prevention; two counties which include portions of the Lake of the Ozarks are focused on drowning prevention; one rural area is focused on farm safety; and others are focused on the prevention of child abuse/neglect.

Adverse Birth Outcomes:
The majority of the counties focused on this area are addressing the prevention of teen pregnancies and identification and treatment of sexually transmitted diseases; several others are addressing the importance of adequate nutrition during the prenatal and post-

partum periods, including assuring those women eligible for WIC are referred for services; and one county is working with the local health care providers to assure women of reproductive age have access to smoking cessation resources.

Obesity Prevention:
Several counties plan to increase public awareness about good nutrition and the importance of physical activity through media campaigns, web information, working with community obesity prevention leaders; some are working with local schools, churches and local food pantries to increase access to healthy food choices; another county is working to establish a Farmer's Market to increase access to fresh fruits and vegetables for residents; others are working to increase access to opportunities for physical activity such as complete streets, a public park system, walking and biking trails; promoting breast feeding; and working with the University Extension for technical assistance to the community.

Tobacco Prevention:
Several counties state they will work with their local business leaders on establishing smoke-free businesses and eating establishments; while others will focus on education to children and teens regarding the prevention of tobacco use (smoking and smokeless) and establishing student advocacy groups.//2013//

/2013/Evaulation

Prior to development of the current MCH contracts the CLPHS conducted a structured evaluation of the program. Surveys were completed by LPHA contractors assessing the strengths and challenges of the contracts along with identifying current practices relating to the life course perspective and cultural competence. In addition, each LPHA identified their MCH priorities for the next 3 years. Combining the survey findings, the 5 year State MCH Needs Assessment, and our program specific knowledge of how best to guide contractors into systems thinking and the inclusion of a focus on life course perspective/cultural competency, a new contract was developed using the spectrum of prevention model. Within the contract there are clear expectations for each contractor to evaluate their own activities and progress towards reaching the system outcome for each of the six levels of prevention. Pre/post tests, surveys, and meeting minutes are used frequently throughout the work plans.

All programs in DHSS complete an evaluation of their goals, objectives and activities as part of the budget process. In addition the programs in the Bureau of Genetics and Healthy Childhood each complete a structured evaluation at the start of each calendar year.//2013//

B. Agency Capacity

State Statues

On March 29, 1883, the Missouri Legislature established a state agency responsible for promotion of health and prevention of disease by creating the State Board of Health. Missouri Crippled Children's Service became part of the Division of Health, Department of Social Services in 1974. The Department of Health (DOH) was created in 1985 to supervise and manage all public health functions and programs formerly administered by the Division of Health. Executive Order 01-02 in 2001 transferred the Division of Aging to DOH and formed the Department of Health and Senior Services (DHSS) allowing one department to focus on prevention and quality of life.

RSMo 201 requires the DHSS "to administer a program of service to children who are crippled or who are suffering from conditions that lead to crippling." "The purpose of this service is to

develop, extend, and improve services for locating such children, especially in rural areas, and for providing medical, surgical, corrective and other services and care facilities for diagnosis, hospitalization, and aftercare." This requirement is met through the Children and Youth with Special Health Care Needs Program (CYSHCNP).

RSMo 191.331 passed in 1965 requires every infant born in Missouri be tested for phenylketonuria and such other metabolic or genetic diseases as are prescribed by the department. RSMo 191.332 expanded screenings in 2005 to include cystic fibrosis, biotinidase deficiency, and amino acid, organic acid, and fatty acid disorders.

Missouri has met the goal of screening for all 29 core conditions (including hearing) recommended by the American College of Medical Genetics, the March of Dimes and the Missouri Genetic Advisory Committee. When considering secondary conditions, a total of 67 disorders can now be detected through Missouri's newborn screening program.

RSMo 191.331 was amended in 2007 to expand financial eligibility guidelines for children through age 18 to receive metabolic formula. Any child under age 6 is financially eligible to receive metabolic formula and those children from age 6 through 18 are eligible at 300% of federal poverty level (FPL). DHSS established rules to implement this statutory provision to provide a sliding scale for family incomes exceeding 300% of the FPL so no family pays more than 50% of the cost of formula.

RMSo 191.925 became effective January 1, 2002 and requires Missouri hospitals to screen newborns for hearing loss prior to discharge. RMSo 191.928 includes: the maintenance of a newborn hearing screening surveillance and monitoring system; and the establishment of follow-up procedures to assure appropriate and timely diagnosis of hearing loss, delivery of amplification, and referral for early intervention services.

Funding appropriated in 2004 allowed dental hygienists to bill Medicaid/SCHIP for services rendered under expanded scope of practice per RSMo 332.311 allowing duly registered and currently licensed dental hygienist with at least 3 years of experience, practicing in a public health setting, to provide Medicaid eligible children: fluoride treatments, teeth cleaning, sealants without supervision of a dentist.

RSMo Section 630 incorporates Senate Bill 1003 (Child Mental Health Reform Act) to create the Comprehensive Children's Mental Health Service System to serve children with emotional and behavioral disturbance problems, developmental disabilities and substance abuse problems. By August 28, 2007, and periodically thereafter, the Children's Services Commission shall conduct evaluations of implementation, effectiveness of the system, family satisfaction and progress of achieving outcomes.

OVERARCHING CAPACITY

/2013/MCH Services Program

MCH Services Program has integrated the life course perspective and risk and protective factors into contracts with LPHAs. MCH regional nurses provide technical assistance, consultation and resources to LPHAs and their community partners on evidence-based best practices and developing/maintaining community collaboratives around MCH issues.

MCH Services Program provides funding through contracts with LPHAs to address one of four health issues with their community partners; adverse birth outcomes, injury, obesity, and tobacco prevention. Three year work plans utilize the six levels of the Spectrum of Prevention framework with annual evaluation of progress toward system outcomes. LPHA contract funding may also be used to address local MCH health issues.//2013//

Access to Care

The Missouri Office of Primary Care and Rural Health (OPCRH) operates the Primary Care Resource Initiative for Missouri (PRIMO) program, which allows for the development and implementation of a system of coordinated health care services available and accessible to all Missouri Citizens. The PRIMO program was designed as coordinated incentives to increase the number of primary health care professionals and health care delivery systems in areas of need within the state. This is accomplished through funding primary dental, medical, and behavioral healthcare within safety net settings, providing student loans to aspiring health professionals that agree to work in health professional shortage areas (HPSA), and providing loan repayment to professionals agreeing to work in HPSAs. Additionally, the Rural Health Office provides funding to small rural hospitals and critical access hospitals through contracts to improve quality of care processes (particularly around trauma), customer service, and electronic medical records.

Early Childhood

The Early Childhood Comprehensive Systems (ECCS) grant resides within the Title V agency. The focus is a statewide early childhood comprehensive system that supports families and communities in their development of children that are healthy and ready to learn at school entry. Serving as the guiding body is the ECCS Steering Team which includes representatives of DHSS, Department of Social Services, Department of Elementary and Secondary Education, Department of Mental Health, Head Start Collaboration Office, Children's Trust Fund, and the United Way among others. The ECCS project has a contract with the University of Missouri Kansas City - Institute for Human Development to develop a network of local community groups and a Family Leadership Resource and Referral Clearinghouse. Eighteen local teams are at various stages of development across the state with work just beginning on the development of the family leadership component.

/2013/The Missouri Early Childhood Summit took place in March 2012 with 80 participants. The purpose of the Summit was to strategically examine how to advance Missouri's early childhood efforts in an effective and coordinated fashion that is responsive to the needs of children and families and to ultimately build a cadre of family leaders. Twenty-one family leaders attended pre-Summit sessions to prepare to meet with local and state early childhood professionals. Ideas and concepts at the summit were recorded through the use of graphic interpreters that created a visual display of the conversations and interactions.//2013//

/2013/Coordinating Board for Early Childhood (CBEC) completed its strategic plan which provides an essential roadmap for CBEC work groups and builds upon central tenets of the grant application and effectively anchors the focus of all CBEC activities and expenditures. CBEC actively partnered with the Early Childhood Comprehensive System (ECCS) in development of the plan as a joint effort between the two entities. CBEC remains actively engaged with ECCS in an effort to bridge gaps and enhance communication and linkages with local early childhood communities and systems.

CBEC has contracted with the University of Missouri, pursuant to one of the primary goals articulated in the ECAC application, to conduct a Head Start Data Pilot. Head Start is recognized as a leader and key partner in the early childhood system and the central goal of the pilot is the integration of Head Start data into the state data system. CBEC also contracted with the University of Missouri, to create Early Learning Guidelines for the state, pursuant to goals articulated in the ECAC application. CBEC authorized funds to contract for a comprehensive analysis of fiscal resources in MO, with the goal being to identify strengths, gaps, need, and opportunities for more efficient and effective use of resources.//2013//

Childcare

The Section for Child Care Regulation (SCCR) is responsible for licensing of family and group child care homes and child care centers, staff qualifications, quality initiatives, and inclusion services.

/2013/SCCR also investigates reports of illegal operation of child care facilities.//2013//

The Child Care Health Consultation (CCHC) is a collaborative effort between DHSS and Local Public Health Agencies (LPHAs) to provide health and safety consultation/education to child care providers, parents of children in child care and young children. CCHC assists families and child care providers to access needed health and social service programs, to interpret and implement services for CYSHCN and help prepare health care action plans for children in the child care settings.

/2012/The statewide CCHC program is based upon a professional nursing model and is the largest network of Missouri trainers that direct efforts toward preschool children enrolled in child care settings.//2012//

/2013/The Bureau of Genetics and Healthy Childhood is working with the Section for Child Care Regulation to develop updated rules related to providing a safe sleep environment for infants in the child care setting and assuring child care workers receive annual education on this topic.

Staff in licensed child care facilities must have 12 clock hours of training annually, which the CCHC Program provides free of charge.//2013//

PREVENTIVE AND PRIMARY CARE SERVICES FOR PREGNANT WOMEN, MOTHERS AND INFANTS

Newborn Screening

Missouri's newborn screening program consists of both bloodspot screening and newborn hearing screening. All infants born in Missouri are to be screened unless the parent declines for religious reasons. Early identification and timely intervention by health care providers reduce associated mortality and/or morbidity. The DHSS contracts with four genetic tertiary centers and four accredited cystic fibrosis (CF) centers located in St. Louis, Columbia, and Kansas City to follow-up on abnormal newborn screen results and ensure that confirmed infants are entered into a system of health care. Contracting with these centers greatly improves the outcomes of confirmed positive infants because the primary care provider is: provided accurate information about the disorder; instructed on the appropriate tests for a timely diagnosis and is urged to have the family come to the genetic center as soon as possible; and given instructions on how to treat the child until the child is seen in a genetic or CF center. These centers provide a full complement of medical specialists including genetic and medical evaluations, nutritional and dietary counseling, genetic counseling, and education to the parents about the child's disorder and treatment.

Hearing screeners in hospitals and birthing centers refer infants not passing the initial hearing screen for further screening or for testing by a pediatric audiologist. Follow-up coordinators in DHSS track infants who did not have an initial hearing screen, did not receive a pass result on the initial screen, or are found to be at risk for later development of hearing loss. They will contact the birth hospital, parents, or audiologists as necessary to assure the child is receiving the appropriate care. Infants with hearing loss are referred to the Individuals with Disabilities Education Act (IDEA) Part C (First Steps) Program for appropriate interventions. Missouri is fortunate to have four schools for the deaf and hard of hearing where infants and children may receive the type of assistance the family chooses.

Written correspondence targets the parents of infants born with spina bifida, Down syndrome, or a cleft defect to assure they are aware of resources to enhance the development of their child. Families are invited to contact the Bureau of Genetics and Healthy Childhood (GHC) or the DHSS Birth Defects website for further information.

/2012/Effective April 2010 written correspondence is no longer sent to affected families.//2012//

Home Visiting/Newborn Health

The Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program (BB), the Missouri Community-Based Home Visiting Program (MCBHV), and Newborn Health Program provide education to women on the prevention of birth defects and how to decrease the incidence of preterm births through the daily use of folic acid and by avoiding alcohol, tobacco, and other drugs preconceptually and throughout pregnancy. The education of the clients is also instrumental in decreasing infant deaths due to unsafe sleep practices and shaken baby syndrome, decreasing the rates of prematurity due to inadequate prenatal care and birth spacing less than 18 months apart, and decreasing the incidence of preventable childhood diseases through immunizations. The BB and the MCBHV serve up to 575 pregnant and parenting women at any given time providing them with assessment and primary prevention services.

/2012/The Governor of Missouri designated the DHSS as the lead agency for the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Grant. The ACA Home Visitation Grant will provide services in Pemiscot and Dunklin Counties utilizing Nurse Family Partnership, Early Head Start, and Parents as Teachers models.//2012//

/2013/A Notice of Grant Award received on September 2011 provided additional funding for services under the ACA Maternal, Infant and Early Childhood Home Visitation (MIECHV) program to implement/expand Early Head Start programs in Pemiscot, Dunklin, Butler, Ripley and Jasper Counties; and expand Parents as Teachers services in Dunklin County. Total funding under the ACA MIECHV will allow for early childhood home visitation services to 319 families.//2013//

Newborn Health (additional)

/2013/Text4baby, a free mobile information service of the National Healthy Mothers Healthy Babies (HMHB) Coalition delivers free text messages on important maternal and child health topics to pregnant women and new moms who enroll in the program. Since the launch of the service on February 4, 2010 through FFY 2011, 7,892 Missouri women have registered to receive Text4baby messages.//2013//

/2013/Funding from the FTMNP has been used to customize the Text4baby messages to utilize Missouri specific 800 phone numbers in the messages. Three themes for the social marketing campaign were developed and tested in15 focus groups throughout the state. After review by the Department's Administration the theme "It All Counts" was chosen. With this theme as the foundation, radio ads were developed and aired on the importance of physical activity and nutrition. In August 2011 an "It All Counts" Facebook page made its debut and currently has more than 2,000 "friends ".//2013//

PREVENTIVE AND PRIMARY CARE SERVICES FOR CHILDREN AND ADOLESCENTS

Oral Health

The Oral Health Program (OHP) implemented the Preventive Services Program (PSP) a community-driven, systematic approach to population-based prevention of oral disease. The goal of the program is to assess the oral health status of children while providing a public health

preventive intervention. The program involves local dentists and hygienists conducting an oral screening annually on as many children in the community as possible, accompanied by oral health education, application of fluoride varnish, and referral for necessary dental work to local clinicians. The OHP provides the fluoride varnish supplies and local dental professionals supply the manpower to accomplish this community-based approach.

School Health

/2012/Contract funding (General Revenue) was eliminated in June 2010. The focus has now shifted to an emphasis on statewide consultation.//2012//

/2013/The School Health Program is primarily responsible for providing technical assistance to school nurses, other school personnel, parents and health care providers on all aspects of the school health program and facilitating workforce development for school nurses via web based learning and conferences.//2013//

Injury Prevention

The Injury and Violence Prevention Program provides targeted prevention interventions to children ages 0-14 through contracts with eight Safe Kids Coalitions. These coalitions provide services in fifty-one counties and the cities of St. Louis and Kansas City. Safe Kids Coordinators are based in a lead agency in the community such as a hospital or local health center and work closely with other community partners.

/2013/The Injury and Violence Prevention Program continued providing services to reduce injuries in Missouri through the contracts with local Safe Kids Coalitions. Safe Kids Cape Girardeau dropped the contract and New Safe Kids North West Coalition was awarded, providing services in 38 counties including the cities of St Louis and Kansas City.//2013//

Adolescent Health Program (AHP)

AHP addresses various adolescent health status indicators and issues. The program provides consultation education, training, and resources to assist health professionals, school personnel, parents, adolescents, state agencies, and community agencies. Council for Adolescent and School Health (CASH) assists DHSS in identifying adolescent health priorities and promoting strategies to reduce health risks to adolescents. CASH has advised on national efforts as well, including the Healthy People 2020 objectives.

Teen Outreach Program (TOP) contracts support local efforts to promote healthy youth development, improve academic outcomes, and reduce teen pregnancy. AHP coordinates three collaborative projects to promote evidence-based teen pregnancy, STD, and HIV prevention and preconception health for adolescents. AHP also contracts with school, community, and faith-based organizations to implement abstinence education and youth development programs for adolescents and parent-child sexuality education programs.

In 2006 and 2009, DHSS completed an adolescent health system capacity assessment across 30 programs and services for adolescents (ages 10-24) and their families. Based on the results of the assessment, the DHSS Adolescent Health Leadership Team was formed to strengthen capacity and coordination of DHSS services and programs and serve on the CASH.

/2013/AHP directs the PREP which supports the replication and evaluation of evidence-based healthy youth development, teen pregnancy, STD, and HIV prevention programs in some of the highest need counties and populations, including youth in foster care. The Abstinence Education Grant Program is now administered in the BHP with the new faith-based initiative. Programs for high risk youth and statewide media strategies to increase parent communication with adolescents are conducted.//2013//

/2013/In 2011 DHSS appointed Pat Simmons, Nutrition Specialist, as the Department's Obesity Initiative Coordinator. She has been working with internal and external partners to coordinate obesity prevention efforts focused on policy and environmental changes at the state and local level. The Department's priority areas are farm to institution and Livable Streets. Training, resource development and media exposure have been targeted to stakeholders in these two areas.//2013//

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)

Special Health Care Needs Program (SHCN) develops, promotes and supports community-based systems that enable the best possible health and highest level of independence for Missourians with special health care needs. SHCN provides services for children and adults with disabilities, chronic illnesses and birth defects. Services include in-home assessments, authorization of treatment, and service coordination. SHCN promotes family-centered, community-based, coordinated care. Activities are focused around National Performance Measures and HRSA's 6 Key Systems Outcomes for children with special health care needs related to medical home, insurance coverage, screening, organization of services, family participation\satisfaction, and transition to adulthood.

Children and Youth with Special Health Care Needs Program (CYSHCNP) is administered through SHCN to provide early identification and health services, including service coordination for participants birth to age 21. The name of the program was changed in March 2010 to CYSHCNP to better reflect the population served.

Administrative Case Management (ACM) is provided through an agreement SHCN has with the Department of Social Services, MO HealthNet Division (Medicaid). SHCN authorizes medically necessary in-home nursing services and provides service coordination for participants in the Healthy Children and Youth (HCY) Program and the Physical Disabilities Waiver (PDW) Program. HCY participants are under the age of 21 and PDW participants are age 21 and over.

/2013/The July 2011 waiver application renewal changed the name of the Physical Disabilities Waiver Program (PDW) to the Medically Fragile Adult Waiver Program (MFAW) to more accurately reflect the population served.//2013//

The Service Coordination Model is used to articulate the service coordination process (see attached). Service Coordinators (SCs) are located within each participant's region and complete the Service Coordination Assessment (SCA) in collaboration with participants/families to determine individual and family strengths, needs, and unmet goals. Participants/families are linked with healthcare and community services at the local level. The SCA is a person centered, comprehensive assessment, which includes assessing National Performance Measures related to CYSHCN. It was developed with participants/families to achieve the best possible health and highest level of independence for SHCN participants. In addition, transition plans are completed by SCs with participants/families and team members (health care professionals, school personnel, state or community agencies, etc.) to address participants' needs.

Additional providers are recruited to improve availability of services to participants. SHCN places provider enrollment forms on the Internet and maintains provider enrollment information in the Missouri Health Strategic Architecture and Information Cooperative (MOHSAIC) system for access by SCs.

Through a contract with Missouri Assistive Technology, SHCN provides home access improvements, vehicle access, and a range of assistive technology devices for CYSHCN.

The Adult Head Injury Program facilitates the Missouri Head Injury Advisory Council (MHIAC) which makes recommendations for improvement of systems to meet needs of those with

traumatic brain injury (TBI) and serves in an advisory role to the Federal TBI Implementation Grant awarded to DHSS. This grant is funded through the Health Resources and Services Administration for 2009-2013 with the overall goal "to provide individuals with traumatic brain injuries and their families with improved access to comprehensive, multidisciplinary, coordinated and easily accessible systems of care."

/2013/In April 2011 the Section for Special Health Services was formed. This section includes Special Health Care Needs and the Adult Head Injury Unit. In July 2011 SHCN made program name changes to better reflect the population of Missourians that SHCN serves. The name of the Physical Disabilities Waiver Program changed to Medically Fragile Adult Waiver Program. The name of the Adult Head Injury Program was changed to the Adult Brain Injury Program. In April 2011 the Adult Brian Injury Program became the Adult Head Injury Unit within the Section for Special Health Services.//2013//

SHCN collaborates with external entities to: increase organization of community-based service systems; determine participants' current Medicaid status; receive referrals of children applying for SSI from the State Disability Determination Unit (DDU); and coordinate statewide, multi-agency efforts for participation in local, regional and state disaster response planning activities.

/2013/The CCHC Program offers training and consultation to child care providers and parents on inclusion of children with special health care needs (CSHCN).The Program conducted 159 hours of combined training/consultation on the topic of CSHCN and reached 841 child care providers and 15 parents.//2013//

Through the Section for Child Care Regulation (SCCR), Child Care Resource and Referral (CCRR) provides referrals for families to child care programs. Referral Specialists collect data (immunizations, diseases, birth defects, developmental issues and insurance status, etc.). Inclusion Specialists ensure appropriate placements for CYSHCN and provide training and technical assistance to child care homes and centers to accommodate CYSHCN.

The State School Nurse Consultant provides consultation to school nurses, Missouri School Boards' Association, Missouri Rural Educators Association, Department of Elementary and Secondary Education (DESE), and others regarding the development of individualized health care plans for CYSHCN in the school setting.

OTHER CAPACITY

Collaboration Capacity

/2013/The CCHC Program collaborates with the Bureau of Immunization Assessment and Assurance and the Section for Child Care Regulation to support rules pertaining to immunization compliance, by offering clock hour training and consultation to child care providers. A continued partnership with the Child and Adult Care Food Program has allowed the CCHC program to provide training and consultation about obesity prevention. Through a recent partnership with the Lead Program the CCHC Program plans to offer training to support rules regarding testing of young children in designated high-risk areas.//2013//

The Missouri Newborn Hearing Screening Program (MNHSP) receives funding from the CDC to establish an electronic data management system that will link to bloodspot newborn screening and vital records. The MNHSP data management system is part of the Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) a larger, integrated system that incorporates many DHSS programs. Currently, MOHSAIC provides the MNHSP with data entry capabilities for hearing screening results, case management, and statistical reports. The MNHSP also receives funding from HRSA for reducing loss to follow-up following failure to pass the initial hearing screening.

The MNBSP collaborates with the Missouri Genetic Advisory Committee, the Heartland Regional Genetics and Newborn Screening Collaborative, and the National Newborn Screening and Genetics Resource Center. The purpose of collaboration is to enhance, improve, or expand the ability of MNBSP to provide quality health care to newborns and children at risk for heritable disorders. Collaboration with Heartland has consisted of: collecting information on transfusion practices in hospitals and blood banks; developing family emergency preparedness plans; and reviewing states' newborn blood spot screening reports to look for areas of improvement and harmonization of basic information.

/2012/Missouri is participating in the Newborn Screening Translational Research Network. This network is developing a system for researchers nationwide to access data on rare diseases. The group is currently focusing on the Lysosomal Disorders.//2012//

MCH Services staff serve on the Injury Prevention Advisory Committee and Council for Adolescent and School Health and assisted GHC in implementing folic acid education pilots with area high schools utilizing University of Missouri nursing students.

/2012/The SHCN Adult Head Injury Program partners with the Missouri National Guard, Veterans Commission, Veteran's Administration, and Military Life Consultants in promoting awareness of Traumatic Brain Injury (TBI). Information and self screening pamphlets designed specifically for the military service population, and publications including Missouri specific resources for guardsmen and their family members, have been developed and disseminated through these collaborations. The TBI Implementation Partnership Project grant funded the printing of publications. DHSS is awarded the grant through the Health Resources and Services Administration. The grant is funded from 2009 through 2013 with the overall goal "to provide individuals with traumatic brain injuries and their families with improved access to comprehensive, multidisciplinary, coordinated and easily accessible systems of care.//2012//

/2013/MCH Services Program staff continue to serve on the Injury & Violence Prevention Advisory Committee, Epilepsy Foundation, Teen Pregnancy Prevention Partnership Board, Council for Adolescent and School Health, MO Council on Activity and Nutrition, Council for Public Health Nursing, Show-Me Bright Futures Collaborative with DMH, Missouri Rural Development Partnership, Maternal Child and Family Health Coalition in St. Louis and the Maternal Child Health Coalition in Kansas City. Discussions with Missouri Foundation for Health, a private funder, identified gaps in funding for MCH priority health issues resulting in change of focus and new grant opportunities for LPHAs/community organizations. Nursing staff provided state wide training to Headstart Directors on the Bright Futures in Mental Health public health model. Collaboration with Headstart and the University of Missouri to provide state-wide train-the-trainer sessions to LPHA nurses on the AAP Healthy Futures Medication Administration in Child Care Curriculum. Program staff collaborate with DHSS WIC, CACFP, immunizations, school health, adolescent health, lead, injury and obesity prevention programs to assure consistent messages/share resources and current program strategies and goals with our LPHA partners.//2013//

SHCN partners with Missouri Family Voices and University of Missouri Kansas City -- Institute for Human Development (UMKC-IHD) on a grant to establish a Family to Family Health Information Center. The goal of this project is to provide information, training, and personal support to families of CYSHCN.

/2012/Original grant award ended May 31, 2011. Funding was extended thru 2012 by the Affordable Care Act.//2012//

SHCN partners with UMKC-IHD on a grant for service integration. The goal of this project is to improve and sustain access to quality comprehensive, coordinated community based systems of services for CYSHCN and their families.

/2012/Grant funding ends May 31, 2011. Missouri is not currently eligible to reapply for this grant because the state received the maximum award of three years funding.//2012//

SHCN partners with University of Missouri Columbia (UMC) Thompson Center for Autism and Neurodevelopmental Disorders on a grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities.

/2012/Grant award funded from September 1, 2008 through August 31, 2011. UMC Thompson Center for Autism and Neurodevelopmental Disorders, in partnership with SHCN, has applied for a fourth year of funding.//2012//

/2013/Grant funding was awarded from September 1, 2012 through August 31, 2015 for the UMC Thompson Center for Autism and Neurodevelopment Disorders partnership with SHCN.

The University of Missouri- Kansas City (UMKC) in conjunction with Special Health Care Needs received a grant award to enhance care coordination for urban families with children and youth with special health care needs through integration of a parent-to-parent model of peer support within pediatric care clinics. The grant period is September 1, 2011 through August 31, 2014.//2013//

SHCN participates in the Missouri Assistive Technology Council, Missouri Planning Council for Developmental Disabilities, and the Missouri Commission on Autism Spectrum Disorders. The Title V Director serves on the State Interagency Coordinating Council for the IDEA Part C (First Steps) Program.

/2013/In addition to the above SHS participates in SICC and The Missouri Drug Endangered Children's Taskforce (MODEC).//2013//

The State School Nurse Consultant and the School Health Program have active collaborations with the Missouri School Boards' Association, Parents Teacher Organization, the Office of Homeland Security, Safe Schools Task Force, the Farm to School Initiative, the Missouri Association of School Nurses and the Coordinated School Health Coalition.

/2012/AHP and OWH co-lead Preconception Health for Adolescents (PHA) Initiative in collaboration with DESE, AMCHP, University of Missouri Extension, DHSS First Time Motherhood Grant staff, and other internal and external stakeholders to develop health curriculum and online resources to educate teens and young adults about the importance of preconception health.//2012//

/2013/Injury and Violence Prevention Program has active collaborations with Missouri Coordinated School Health Coalition, Missouri Coalition for Roadway Safety and CDC Regional Network (RNL) Program.

Obesity Prevention Program has active collaborations to improve children's access to healthy food and safe places to be physically active with the following: Missouri Council for Activity and Nutrition (MOCAN), University of Missouri Extension, Department of Elementary and Secondary Education, Department of Natural Resources and the Midwest Dairy Council.//2013//

Culturally Competent Care

Various activities occur across programs on an ongoing basis to address cultural competency. For example:

A wide variety of Missouri's resources are available in both English and Spanish.

A one-day Missouri Genetic Conference, "Newborn Screening: What Providers and Parents Need to Know", was held to provide education on the expansion of Missouri's newborn screening program. Attendees included physicians, dieticians, nurses, genetic counselors, social workers and other health care professionals and also families having a child with a metabolic/genetic disorder or a hearing disorder. Conference topics included an overview of the expanded newborn blood spot screening in Missouri, newborn hearing screening, a closer look at sickle cell disease, cultural competency, transitioning CYSHCN to adult care, setting up parent support groups, and others.

Missouri Newborn Hearing Screening Program (MNHSP) staff and Kansas City MOHear (service coordinator for infants who are deaf or hard-of-hearing) periodically attend cultural competence training including a presentation on the use of health services by refugees in Missouri. The MNHSP provides parent informational brochures in English, Spanish, Bosnian, and Vietnamese. Informational flyers on hearing loss and risk factors for late-onset hearing loss are printed in English and Spanish. Follow-up coordinators (FCs) utilize interpreting services during phone calls to families. FCs have been trained to say, "please wait while I get a translator," in Spanish.

In order to make newborn hearing screening available to Amish and Old Order Mennonite communities, the MNHSP collaborates with two midwives and one nurse practitioner with ties to these communities. The MNHSP loaned portable hearing screening equipment and provided training in use of the equipment. In return, the hearing screeners report results to the MNHSP and tracking and follow-up is initiated as needed.

The Missouri Sickle Cell Anemia Program (MSCAP) contractors are required to have information and education materials available in a variety of culturally competent formats and provide other services, including foreign language translators and interpreters for hearing impaired.

The statewide media campaign, Talk with me, to encourage parents to talk with their kids about sex, abstinence, and other healthy decisions included ads with diverse youth and parents as messengers.

/2013/MCH Services Program in partnership with MPHA and LPHAs provided a national speaker on the culture of poverty for the annual public health conference. Program staff will be reviewing state-wide census data to identify and map locations of diverse cultures. Staff will share information with LPHAs, identify training needs and research strategies to reach diverse population.//2013//

In SHCN Service Coordinators (SCs) and SHCN staff members participate in numerous activities and events to increase knowledge and awareness of cultural diversity for example; the American Indian Council Symposium, Cultural Sensitivity Classes, Vietnamese American Community Committee, the St. Louis Black Expo and others. A cultural sensitivity training was provided for all SHCN SCs and additional staff in 2009. SHCN monitors changing demographics and address changing needs with translation of SHCN letters and forms utilized by non-English speaking participants/families. SHCN had multiple forms translated into 8 languages to better serve individuals with limited English proficiency. SHCN funds a language line service and interpreters for SCs to communicate with individuals with limited English proficiency. The CYSHCNP and the Family Partnership (FP) contracts contain language including cultural competency requirements.

/2012/One SC took sign language classes at a local community college and forms were translated into 1 additional language. Furthermore, the Traumatic Brain Injury Grant funded the development of "Building Capacity to Work with Diverse Populations". The curriculum has been used to train direct care staff and provider organizations.//2012//

/2013/PREP contractors are required to collect information regarding ethnicity, race,

family, and other demographics, and to be inclusive of LGBTQ youth. These issues are addressed in training and individualized technical assistance sessions provided by AHP. For a contractor that serves a high percentage of families representing 40 nationalities and various cultures, AHP trained 14 translators to educate parents about the program so they will understand and consent to their adolescent child's participation.//2013 //

SHCN translated forms in Burmese and Russian. In addition to the above stated activities, SHCN disseminated materials and resource information in Spanish at the Cambio De Colores Conference in Kansas City and the Bi-National Health Fair in St. Charles Missouri.//2013//
An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

Organization charts for the State of Missouri, Department of Health and Senior Services and the Division of Community and Public Health are attached to this section.

It is through the executive branch of Missouri's government that the greatest proportions of state services are delivered. The Missouri Constitution provides for 16 specific departments, of which one is the Department of Health and Senior Services (DHSS). Within each executive department exists a variety of offices of varying size and scope which deal with specific services. DHSS services are organized under the Department Directors Office in four Divisions. The Division of Community and Public Health (DCPH) is the largest of the four divisions and provides a majority of the services to the maternal and child populations.

Division of Community and Public Health (DCPH)

DCPH is responsible for supporting and operating more than 100 programs and offices addressing public health issues such as: communicable disease control; chronic disease management; health promotion activities; children and youth with special health care needs (CYSHCN); genetic health conditions; cancer; pregnancy and pediatric conditions; vital statistics; oral health; health care access; local public health agencies; etc.

DCPH is organized into four Sections with other various Centers and Offices reporting directly to the Division Director's Office.

Included in DCPH is the Section for Healthy Families and Youth (HFY) which is the Title V agency for Missouri and is made of two primary units, the Bureau of Genetics and Healthy Childhood (GHC) and the Bureau of Special Health Care Needs (SHCN).

GHC promotes and protects the health and safety of individuals and families based on their unique conditions, needs and situations, utilizing multiple programs within the bureau. The bureau achieves this by implementing prevention and intervention strategies to optimize health and environment from pre-pregnancy through adulthood. Related activities of the bureau encompass public and professional education; screening and follow-up services; surveillance; needs assessment; and resource identification and/or development. The bureau accomplishes its mission in collaboration with families, health care providers and other community, state and national partners.

SHCN provides statewide health care support services, including service coordination, for children and adults with disabilities, chronic illness and birth defects. Service coordination is essential for people with complex conditions and needs. SHCN administers multiple programs and initiatives including: the Children and Youth with Special Health Care Needs Program (CYSHCNP), Healthy Children and Youth Program (HCY), Physical Disabilities Waiver Program (PDW), Adult Head Injury Program (AHI), Missouri Head Injury Advisory Council (MHIAC), and the Family Partnership. In addition, SHCN participates in a number of other initiatives, including

the Missouri Assistive Technology Council, the Planning Council for Developmental Disabilities, and the Missouri Commission on Autism Spectrum Disorders.

/2013/In April 2011 the Section for Special Health Services was formed. This section includes Special Health Care Needs and the Adult Head Injury Unit. In July 2011 SHCN made program name changes to better reflect the population of Missourians SHCN serves. The name of the Physical Disabilities Waiver Program changed to Medically Fragile Adult Waiver Program. The name of the Adult Head Injury Program was changed to the Adult Brain Injury Program. In April 2011 the Adult Brian Injury Program became the Adult Head Injury Unit within the Section for Special Health Services.//2013//

/2013/The Bureau of Health Informatics (BHI) was split into two bureaus, Bureau of Vital Statistics (BVS) and Bureau of Health Care Analysis and Data Dissemination (BHCADD), to more adequately divide the tasks each unit performs. BVS handles data requests and analysis for vital records data (live births, fetal deaths, general mortality). BHCADD is responsible for data requests and analysis on the Patient Abstract System (PAS, e.g. hospital discharge data) and promotion and training for the MICA websites.//2013//

Bureau of Health Informatics (BHI) is the primary source for health data within the state. BHI oversees the statistical support and health care monitoring activities of Department of Health and Senior Services (DHSS); collects, analyzes and distributes health-related information which promotes better understanding of health problems and needs in Missouri; and highlights improvements and progress achieved in the general health status of Missourians. MCH-related data files created and maintained by BHI include the Patient Abstract System (PAS), birth defects surveillance, induced termination of pregnancies, live births, fetal deaths, maternally-linked births, multiple-birth file, linked birth-PAS File, linked birth-Medicaid file, and the linked motor vehicle crash records-PAS file.

/2013/BVS prepares the vital records datasets which include: birth defects surveillance files, induced termination of pregnancy files, live births, fetal deaths, maternally-linked births, multiple-birth file, linked birth-PAS file, and the linked birth-Medicaid file. BHCADD prepares PAS and the linked motor vehicle crash data.//2013//

BHI produces and maintains the Missouri Information for Community Assessment System (MICA), an interactive system that allows the user to create and download tables, based on selected variables such as race, ethnicity, age, education, and location. The MICA system has many modules addressing maternal and child health, including births, fertility rate, pregnancies, WIC Prenatal, WIC Postpartum, WIC linked Prenatal-Postpartum, WIC Infant, and WIC Child. The Birth MICA module offers tables and maps for all counties, zip codes, and the three largest cities in Missouri. This module will undergo extensive changes this year to address the added information from the new birth certificate, and to incorporate new indicators such as BMI and Behavioral Risk Factor Surveillance System (BRFSS) regions.

BHI also produces the Community Data Profiles which are resource pages that provide information on a variety of indicators that include MCH indicators. The Profiles include a definition of the indicator, risk factors, and descriptions of diseases and conditions. Our community profile system offers many profiles that contain maternal and child health indicators, including Child Health, Deliveries, Infant Health, Prenatal, Women's Health, and Minority Health. Most profiles are available with break out data by region, county, selected cities, and by race.

/2012/New indicators have been added to birth MICA including Fetal Deaths, Late Fetal Deaths (28 weeks or more) and BMI. Adequacy of prenatal care measures were recalculated in 2010 using the Kotelchuck Index. BRFSS regions have been added as an additional level of geographic analysis to the Birth, Fertility Rate and Pregnancy MICAs.//2012//

/2012/The previous four sections will now be organized into seven sections which will still report

to the Division Director's Office. In the Division Director's Office will be two Deputy Division Directors. Each Deputy Division Director will have oversight responsibility for a subset of the new sections.

Melinda Sanders, Title V Director is one of the new Deputy Division Directors and will have oversight responsibilities for: the Section for Healthy Families and Youth, the Section for Special Health Services, the Section for Health Promotion and Chronic Disease Prevention, and the Section for WIC and Community Nutrition Services. The Title V Agency's placement in the Division Director's Office will provide the Title V Director a more encompassing view of programs specific to the maternal and child population.

Scott Clardy is the other new Deputy Division Director and will have oversight responsibility for: the Section for Environmental Public Health, Section for Communicable Disease Prevention and Control, Section of Epidemiology for Public Health Practice, and the State Epidemiologist.

/2013/The MCH Services and CCHC programs reside in the Center for Local Public Health Services. CLPHS staff provides leadership, training and technical assistance to LPHA contractors, communities, not-for-profit organizations and other health-related key stakeholders regarding the development of processes that improve maternal child health.//2013//

The attached Organization Structure provides a detailed listing of the Sections, Bureaus, and Offices within DCPH and the programs they manage.//2012//

Division of Regulation and Licensure (DRL)

The DRL has responsibility for a spectrum of services for Missouri citizens from child care to elder issues, as well as the Family Care Safety Registry, the Board of Nursing Home Administrators, and the Certificate of Need program. Included in DRL is the Section for Child Care Regulation (SCCR) which is responsible for the licensing and regulation of child care facilities in Missouri. The section licenses family child care homes that provide child care for up to ten children; group child care homes for 11-20 children; and, child day care centers of 20 or more children, dependent upon available space, staff qualifications and other requirements that impact children's health and safety. The section regulates license-exempt child care programs. These include child care programs operated by religious organizations and nursery schools.

Division of Administration

The Division of Administration provides fiscal, administrative and general services support to all department units. Services include budgeting, accounting, expenditure control, procurement, grant administration, internal control and procedure review, legislative review and general office support.

Division of Senior and Disability Services

The Division of Senior and Disability Services is the designated State Unit on Aging, carrying out the mandates of the State of Missouri regarding programs and services for seniors.

/2013/In an effort to increase health equity among Missourians the Department established the Center for Health Equity in January 2011. The CHE is composed of three offices: The Office of Minority Health, The Office on Women's Health, and the Office of Primary Care and Rural Health.

a. The Office of Minority Health (OMH) was created to improve health equity among all Missourians, with a focus on minority populations. The OMH develops public health interventions and provides evidence- based culturally sensitive and competent technical

support to assist in decreasing the rate of health disparities between minorities and the general communities. The OMH partners with six Regional Minority Health Alliances, faith based agencies, community based organizations, and senior citizen groups that serve as a voice of advocacy for the community to identify and improve the health status of minorities. The OMH provides necessary health and medical information, data, and staff resources to ensure health equity for Missourians.

b. The Office on Women's Health is committed to the development of effective, comprehensive public policy that assures gender equity and health equality, promotes improved physical and mental health and lessens the burden of preventable disease and injury among Missouri girls and women. The office collaborates with internal and external partners to enhance the programs and services affecting women, promotes communication, and works for improved coordination of all programs and services affecting women's health. It serves as a resource for communities, the department, local public health agencies, other state agencies and public and private entities serving Missouri women. The OWH also manages the Sexual Violence Prevention and Education program by contracting with non-profit and public health entities to provide focused, community-based sexual violence primary prevention education to the citizens of Missouri. The OWH manages the Sexual Violence Victims Services, Awareness, and Education program by contracting with local service providers to provide advocacy and counseling services to victims of sexual assault in the state of Missouri.

c. The Office of Primary Care and Rural Health (OPCRH) seeks to increase access to quality healthcare services for all Missourians. Through the Primary Care Office, State Office of Rural Health, Primary Resource Initiative for Missouri, Oral Health Program, Nurse Student Loan Program, Healthcare Access Initiative Fund, and the Medicare Flexibility program, OPCRH works with a wide-reaching, diverse group of collaborators to address healthcare access issues.

The OWH is collaborating with CHE and all Divisions in DHSS to develop a standardized data set for all programs in DHSS. This will allow DHSS to collect data that will better determine inequities in health care for Missourians and allow DHSS programs to better identify and target populations most at risk for poor health outcomes.//2013//

/2013/An attachment is included in this section. IIIC - Organizational Structure.//2013//
An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Maternal and Child Health Related Full Time Employees (FTE)

The Division of Community and Public Health employs a total of 740.04 FTE. There are 586.55 FTE located in the Central Office and 153.49 FTE located in other regions across the state. Within the Healthy Families and Youth section, there are 4 Administrative FTE located in the Central Office. Genetics and Healthy Childhood employs 26 FTE within the Central Office, and 3 FTE in other locations across the state. Special Health Care Needs employs 19 FTE within the Central Office and 41 FTE in other locations across the state.

/2012/The Division of Community and Public Health employs a total of 714.53 FTE. There are 564.57 FTE located in the Central Office and 149.96 FTE located in other regions across the state. Within the Healthy Families and Youth section, there are 3 Administrative FTE located in the Central Office. Genetics and Healthy Childhood employs 26 FTE within the Central Office, and 3 FTE in other locations across the state. Special Health Care Needs employs 19 FTE within the Central Office and 40 FTE in other locations across the state.//2012//

/2013/The Division of Community and Public Health employs a total of 730.00 FTE. There

are 584.04 FTE located in the Central Office and 145.96 FTE located in other regions across the state. Within the Healthy Families and Youth section, there are 3 Administrative FTE located in the Central Office. Genetics and Healthy Childhood employs 21 FTE within the Central Office and 2 FTE in other locations across the state. Special Health Care Needs employs 12.49 FTE within the Central Office and 41 FTE in other locations across the state //2013//

Senior Level Management

Also see the attachment to the preceding section, III. State Overview, C. Organizational Structure.

Glenda R. Miller, RN, MPH, BC CHNCS, became the Director of the Division of Community and Public Health (DCPH) in August 2005; she had previously been Director of the former Division of Maternal, Child and Family Health located in the Department of Health and Senior Services (DHSS). Ms. Miller's diverse background includes serving as: Director of Center for Local Public Health Services where she developed and monitored the Core Public Health Functions contract in 114 counties and evaluated effectiveness and efficiency of the public health system; Education/Training/Social Marketing Coordinator for Burrell Behavioral Health where she developed education and training for System of Care Federal Grant, designed a strategic plan for social marketing and coordinated training and social marketing for multiple agencies in six counties; Project Evaluator, Sinclair School of Nursing for University of Missouri-Columbia; Faculty Instructor for Southwest Missouri State University; Faculty/Instructor for Webster University; Director, Disease Management and Health Risk Assessment for Cox Health Plans; Medicaid Special Programs Manager for Cox Freeman Health Management Services; HIV/AIDS Care Service Coordination (Emergency Appointment) for Missouri Department of Health; Assistant District Administrator for Missouri Department of Health for 21 counties in Southwest Missouri; and Community Health Nurse Consultant for Missouri Department of Health. /2012/Retired from the Department of Health and Senior Services in January 2011.//2012//

Harold Kirbey, BS in Sociology and graduate work at UMC in Rural Sociology, was appointed Deputy Director of DCPH, November 1, 2006. Mr. Kirbey has served DHSS since 1987 in the positions of Health Program Representative, Management Analyst Specialist II, Bureau Chief and Chief of Office of Primary Care and Rural Health. His experience with DHSS, the legislature, LPHAs, primary care providers and other public health partners serve DCPH well. /2012/Effective March 2011, Mr. Kirbey is now the Director of the Division of Community and Public Health.//2012//

Kerri Tesreau, MBA, is the Director of Operations for the Division of Community and Public Health (DCPH). Mrs. Tesreau is primarily responsible for oversight of the Office of Financial and Budget Services (OFABS) and state budget preparation, analysis and tracking for the Division. Additional duties include distribution, coordination, tracking and approval of legislative bill reviews and fiscal notes, preparation of routine and special fiscal reports, and the approval of grants, contracts and expenditures.

Melinda Sanders, MS(N), RN, is the Section Administrator for Healthy Families and Youth (HFY) in DCPH and the Title V Director for Missouri with responsibility for the Title V Block Grant application and statewide MCH need/capacity assessments. She began her work at DHSS in 1998. Ms. Sanders has 31 years of nursing experience, including 12 years as a Family Nurse Practitioner. While at DHSS, Ms. Sanders worked as a Consultant Community Health Nurse for children with special health care needs and Chief of the former Bureau of Genetics and Disabilities Prevention before becoming Section Administrator. Ms. Sanders holds Bachelor and Master of Science degrees in Nursing from the University of Missouri-Columbia. /2012/In April 2011, Ms. Sanders was promoted to Deputy Division Director of DCPH.//2012//

/2012/Also in April 2011, Scott Clardy was appointed as Deputy Division Director for DCPH. Mr.

Clardy has over 23 years of experience in public health including experience in the fields of immunizations, childhood lead poisoning prevention, communicable disease investigation and prevention, environmental health, vital records, public health informatics, public health laboratory sciences, and public health emergency response. Mr. Clardy currently serves as Missouri's representative on ASTHO's State Environmental Health Directors. Mr. Clardy holds a B.S. in Biochemistry. //2012//

Cindy Wilkinson, MSW, is the Deputy Section Administrator for DHSS, DCPH, HFY. Ms. Wilkinson is an experienced administrator with expertise in various aspects of children's healthy development, including 25 years with the Children's Division, Department of Social Services working in the area of child protective services. Ms. Wilkinson holds a Bachelor of Science degree in Family and Environmental Resources from Northwest Missouri State University-Maryville and a Masters in Social Work from the University of Missouri-Columbia. /2012/Ms. Wilkinson is now the Section Administrator for the Section for Healthy Families and Youth.

Lyn Konstant is the Administrator of the Section for WIC and Community Nutrition Services.

/2013/Lyn Konstant retired in early 2012 and Lisa Brown was promoted to the position of Administrator for the Section of WIC and Community Nutrition Services. She holds both a bachelor's degree in Psychology and in Sociology. She is an attorney who served as a juvenile staff attorney, primarily focusing on abuse and neglect cases. Prior to coming to DHSS in 2011 to serve as the Chief, Bureau of WIC and Nutrition Services, she served as the Executive Director of a not for profit. In this capacity she was able to expand programs addressing homelessness, food insecurity, access to rural mass transportation and to improve public awareness of issues facing lower income persons.//2013//

Gary Harbison is the Chief of the Bureau of Special Health Care Needs (SHCN) and the Title V Director of Children with Special Health Care Needs. Mr. Harbison is currently serving as the Interim Section Administrator for the Section for Special Health Services.//2012//

/2013/Gary Harbison resigned in November 2011 and Steve Cramer is the Director of Children and Youth with Special Health Care Needs and the Administrator for the Section for Special Health Services within the Division of Community and Public Health in the Missouri Department of Health and Senior Services (DHSS). Mr. Cramer has both a Bachelors and Masters degree in Sociology and over 16 years of work history specializing in child health and safety issues. Mr. Cramer has held positions as a Coordinator of Children's Programs, Program Coordinator, and Administrator during his four years of employment with DHSS. Prior to joining DHSS Mr. Cramer worked 12 years for the Missouri Department of Social Services holding various positions during that time ending as a Program Development Specialist.//2013//

Epidemiological Capacity

MCH epidemiological capacity is enhanced through an MCH Epidemiology Response Team located in the Section of Epidemiology of Public Health Practice (EPHP), DCPH to focus on maternal and child health related programs and activities. In May 2008, Mei Lin, MD, MSc, became the CDC MCH Epidemiology Assignee to DHSS from the CDC's MCH Epidemiology Program. Dr. Lin is Co-Leader of MCH Epidemiology Response Team with Public Health Epidemiologist Venkata Garikapaty, PhD, MPH. In FFY10 an additional 2.20 FTE were assigned to work with the MCH Epidemiology Response team.

/2013/Dr. Mei Lin, CDC MCH Epidemiology Assignee and Jennifer Collins, CSTE fellow are no longer working for the Missouri DHSS. Jeremy Kintzel, MA, MIS is a Research Analyst IV who joined the MCH Epidemiology Response team and will provide research and analytic support to the Title V MCH Block Grant, the Home Visitation grant, PRAMS, and

other ongoing projects. Jessica Thompson is a Research Analyst III who will provide epidemiological assistance to the home visiting program.//2013//

Parent\Family Initiatives

/2013/The ECCS Steering Committee contracts with the University of Missouri Kansas City, Institute for Human Development, to develop a network of local community groups and a Family Leadership Resource and Referral Clearinghouse.//2013//

The Family Partnership (FP) Initiative was formed by SHCN to enhance the relationship between SHCN and the families they serve. The FP Initiative is implemented by SHCN through a contract with a Local Public Health Agency (LPHA) for statewide activities and provides families of individuals with special health care needs an opportunity to: offer each other support and information; give SHCN input; increase public and community awareness of special needs issues; and promote legislation for programs for individuals with special needs and their families. SHCN materials are distributed for FP members' feedback. Four Family Partners, employed by the LPHA, are paid with SHCN monies. Family Partners are chosen for their expertise as parents or caregivers of individuals with special health care needs. Family Partners conduct regional meetings and a statewide conference for family members/caregivers on an annual basis. Approximately 90 to 100 family members participate in these conferences for the exchange of information and mutual education and support. Family Partners conduct outreach activities to encourage participation in FP meetings. SHCN explored and researched interest groups to assist in the identification and recruitment of youth participation.

/2013/Family Partnership also provided peer support, resource information and education to approximately 4,441 family members and professionals.//2013//

E. State Agency Coordination

Organization relationships among state agencies are illustrated in the attachment to Section III. C. Organizational Structure.

Department of Social Services (DSS)

DSS is responsible for coordinating programs to provide public assistance to children and their parents, access to health care, child support enforcement assistance and to provide specialized assistance to troubled youth.

/2012/DSS houses the Medicaid agency in Missouri.//2012//

The Bureau for Special Health Care Needs (SHCN) Service Coordination staff, Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program, the Missouri Community-Based Home Visiting Program, and the Alternatives to Abortion programs collaborate with other state agencies and local communities to assist in enrolling women, infants, and children in Medicaid. Educational materials distributed by these programs provide information about enrolling children in Medicaid.

/2013/The CCHC Program receives the largest amount of its funding from DSS to provide health and safety training and consultation to child care providers.//2013//

/2012/
The School Health Program (SH) collaborates with DSS related to the Children's Vision Commission. The Department of Health and Senior Services (DHSS) hosts the reporting system for eye care providers, vision screening reports, and referral completions for children failing vision screening exams.
//2012//

SHCN information system links with the Medicaid Agency to provide Medicaid status and easy access for service coordination services. SHCN also has an agreement with the Disability Determination Unit (DDU) to refer children who apply for SSI to SHCN regional offices.

The Office of Primary Care and Rural Health (OPCRH) has a Memorandum of Understanding (MOU) with DSS to provide partial funding for the Donated Dental Services Program (DDS). DDS improves the quality and availability of oral health services to high risk populations. Through the contract, DHSS has established dental services and laboratory dental fabrication for those with seriously neglected dental problems and no means of paying.

MCH Program Manager with DHSS Center for Emergency Response and Terrorism, Section for Child Care Regulation, DSS Children's Division, DSS Family Support Division, and Department of Mental Health are initiating statewide planning for children and disasters.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. The Missouri EPSDT program provides all Medicaid eligible children with appropriate full health screens and subsequent treatment for identified health problems. Outreach efforts for the EPSDT occur under a cooperative agreement between DSS and DHSS to include promotion of age appropriate, periodic screenings. As a component of the MCH contracts Local Public Health Agencies (LPHAs) work to enroll children/families in Medicaid and encourage EPSDT.

Managed care plans have made focused efforts on encouraging EPSDT visits with the adolescent and young child populations. Reminder cards were mailed to parents of young children along with periodicity and immunization schedules. Efforts to reach adolescents include: annual Birthday cards with reminders about well child checks; sending providers a list of teens who were due for a wellness check; mailing teen health newsletters, brochures and website information targeted to 12-14 yr olds; newsletters included immunization information and other screening information (STD); and one plan created a Facebook page on the importance of wellness checks in teens.

/2013/AHP established PREP funded MOU with DSS Children's Division to implement evidence-based teen pregnancy prevention programs for youth in and aging out of foster care.//2013//

Department of Elementary and Secondary Education (DESE)

DESE is the administrative arm of the State Board of Education. It is primarily a service agency that works with educators, legislators, government agencies and citizens to maintain a strong public education system.

The Missouri Newborn Hearing Screening Program (MNHSP) collaborates with the IDEA Part C (First Steps) Program to develop the annual Newborn Hearing Screening Report of aggregate information about children diagnosed with hearing loss and enrolled in First Steps. With parental/guardian permission, First Steps shares the Individual Family Service Plan (IFSP) of children enrolled in early intervention for hearing loss with the MNHSP for data analysis and program development. Additionally, the MNHSP collaborates with First Steps to supplement service coordination for newborns diagnosed with hearing loss using the MOHear Program.

The state school nurse consultant partners with DESE to sponsor new school nurse orientation, coordinated school health conference and the state school nurse annual conference. Guidelines for School Health Services programs are a collaboration among DESE, the State Board of Nursing, and the School Boards' Association.

/2012/The School Health Program partners with the Missouri Elementary School Principals

Association to offer the Olweus Bullying Program in 7 rural school districts.//2012//

/2013/16 rural school districts are implementing the Olweus Bullying Program with fidelity. This year, schools were invited to attend a Community of Practice Collaborative conference to share successes as well as challenges in implementing bullying prevention in rural cultures. A need for information related to LGBQT for these schools was identified and plans are to partner with Department of Mental Health to offer the Trevor Project for these schools.//2013//

DESE representatives actively participate on the Coordinating Board for Early Childhood (CBEC) and the Early Childhood Comprehensive Systems (ECCS) Steering Team.

/2013/AHP collaborates with DESE on An Ounce of Prevention preconception health curriculum training for educators and revising Family and Individual Health Model Curriculum.//2013//

/2013/Obesity Prevention Program collaborates with DESE on training for school food service employees. Training has focused on increasing schools' use of salad bars and meeting the Healthier US Schools Challenge.//2013//

Department of Mental Health (DMH)

The Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program, the Missouri Community-Based Home Visiting Program, and the Alternatives to Abortion programs refer pregnant women using alcohol and other drugs during pregnancy to the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program for treatment. Women who screen positive for depression are referred to their primary care physician or to a mental health provider with the DMH network for further assessment and treatment if necessary.

MCH Services staff participates on state steering committee and provide technical assistance with DMH staff for three pilot sites in Show Me Bright Futures public health model for addressing mental health in children. Collaborative partners are School Health, Department of Elementary and Secondary Education, Children's Trust Fund, MO Student Success Network, Children's Division, Missouri Foundation for Health, and Georgetown University.

SHCN is a partnering agency in the Missouri Autism Rapid Response Initiative, which is a pilot program sponsored by the Department of Mental Health, Division of Developmental Disabilities, designed to improve outcomes for individuals with Autism Spectrum Disorders (ASD) and their families. Parents work with public and private agencies to develop a collaborative, community-based program to enhance early diagnosis and intervention, especially targeting children ages 0-5.

/2013/The School Health Program partners with the DMH programs to offer suicide prevention programs for school staff.//2013//

/2013/Department of Natural Resources

Obesity Prevention Program collaborates with other state agencies, with DNR as the lead, to employ the Children in Nature Program which recognizes communities and families that implement activities including policy and environmental changes that increase contact with nature.//2013//

Local Public Health Agencies (LPHAs)

LPHAs in Missouri are autonomous and operate independently of each other and state\federal public health agencies. MCH Services Program is within the Center for Local Public Health

Services (CLPHS). CLPHS serves as a liaison between other DHSS programs and LPHAs. Through contracts, LPHAs work directly with DHSS to deliver public health services in each of Missouri's communities. MCH Services contracts with 112 of the 114 LPHAs. Six district nurse consultants provide technical assistance, consultation, and monitoring. MCH contracts with LPHAs require developing community collaborations to build sustainable systems to expand resources to address MCH health issues.

LPHAs partner in injury, obesity and tobacco prevention interventions. Some contractors provide home visiting and case management services. Training is provided to support LPHAs and community efforts.

/2013/The MCH Services new 3-year contracts with 114 LPHAs utilize the six levels of the Spectrum of Prevention framework to address one of four MCH health issues: adverse birth outcomes, injury, obesity and tobacco prevention. MCH regional nurses continue to provide technical assistance and resources for school health.//2013//

SHCN maintains contracts with LPHAs to provide service coordination for the Children and Youth with Special Health Care Needs Program (CYSHCNP) and adult survivors of Traumatic Brain Injury and contracts with one LPHA to coordinate the Family Partnership activities statewide.

/2013/AHP contracts with four LPHAs to implement TOP; LPHAs serve on various local coalitions addressing teen pregnancy.//2013//

Federally Qualified Health Care Centers (FQHC)

Through the Primary Care Resource Initiative for Missouri (PRIMO) the Office of Primary Care and Rural Health (OPCRH) is able to allocate funds to safety net providers, such as Federally Qualified Health Centers (FQHC) to implement and sustain primary medical, behavioral, and dental care to uninsured and underinsured populations.

Missouri has 21 FQHC - Community Health Centers (CHCs) with numerous satellite sites throughout the state. Per the HRSA website, there are more than 140 distinct CHC sites operating in Missouri. The Federally Funded CHCs provided primary care, oral health, and\or behavioral health services to over 350,000 individuals in 2008. CHCs are present in every region of the state and serve residents of 111 counties plus the City of St. Louis.

Health Professional Shortage Area (HPSA)

The OPCRH conducts the HPSA survey to determine which counties are eligible to be recommended to HRSA. The survey process takes into account population and provider demographics to determine if access to care is available for all populations.

Tertiary Care Centers

There are 4 university-affiliated genetic tertiary center contracts to support the statewide newborn screening program. The centers provide evaluation for genetic conditions, genetic screening, counseling, and outreach along with tracking and follow-up on all abnormal newborn screen results. Consultation is given to health care providers on those disorders screened by the newborn screening program. Infants found positive for a newborn screened condition are offered medical, nutritional, and genetic counseling services and followed to ensure they are entered into a system of health care.

DHSS contracts with five hospital resource centers to ensure the availability of comprehensive medical services for individuals diagnosed with sickle cell disease. Infants identified with sickle cell disease are referred to the resource centers for follow-up to ensure all infants receive confirmatory testing and appropriate treatment is initiated. This early diagnosis and treatment has

been significant in helping children with sickle cell disease live longer and healthier lives. Other services provided by these centers include: annual physical examinations, follow-up for both medical and non-medical needs, public and professional education to increase awareness of the target population, screening for detection of sickle cell conditions, and genetic counseling to individuals and families identified with sickle cell and other hemoglobin traits.

Missouri Kids First contracts to coordinate three hospital resource centers to provide education, training, and support to physicians, physician assistants and nurse practitioners who conduct medical evaluations of alleged victims of child maltreatment.

SHCN has approximately 380 provider contracts. Through provider agreements with tertiary care centers, pre-approved specialty and sub-specialty care is provided for children and youth with special health care needs (CYSHCN) who otherwise would have no resources for health care services.

Universities

The Missouri Newborn Hearing Screening Program (MNHSP) collaborated with Missouri State University (MSU) to design and implement the MOHear Program consisting of: 1) service coordination for families of newborns diagnosed with severe to profound permanent hearing loss and 2) hearing rescreening for infants who failed or missed the initial hearing screening. Service coordinators (SCs) are professionals with backgrounds in audiology, speech and language therapy and/or deaf education. Since 2007, one SC has worked in the Kansas City region. She accompanies First Steps SCs to the homes of newborns diagnosed with permanent severe to profound hearing loss, provides unbiased information about communication options, and facilitates the majority of the service coordination. Following the receipt of supplemental funding from HRSA, the MNHSP contracted with MSU in 2009 to hire four additional SCs and expand their roles to include follow-up hearing screenings for newborns that fail their initial hearing screening and have no documentation of rescreening or audiologic evaluation. The SCs will use portable hearing screening equipment and meet families in their homes or other convenient locations.

SHCN is represented on the leadership council of Family to Family Health Information and Education Center Grant, the Missouri Partnership for Integrated Community Services for CYSHCN Grant, and the State Improvement Grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities Grant.

/2013/Funding ended May 31, 2011 for the Integrated Community Services Grant. Missouri was not eligible to reapply because the state had already received the maximum award for three years of funding.//2013//

Service Coordinators with SHCN participate in the University of Missouri LEND (Leadership Education in Neurodevelopmental and Related Disabilities) Program trainings and staff provide training at least once annually for the LEND group.

SHCN contracts with the University of Missouri Kansas City - Institute for Human Development (UMKC-IHD) and the University of Missouri Columbia (UMC) to implement activities of the Traumatic Brain Injury Implementation Partnership Grant.

/2013/The University of Missouri Kansas City in conjunction with Special Health Care Needs, received a grant award to enhance care coordination for urban families with children and youth with special health care needs through integration of a parent-to-parent model of peer support within pediatric care clinics. The grant period is September 1, 2011 through August 30, 2014.//2013//

Adolescent Health Program (AHP) and Council for Adolescent and School Health (CASH) is

collaborating with the University of Minnesota (Konopka Institute for Best Practices in Adolescent Health) to develop Understanding Adolescence workforce development training module for MCH programs, contractors, state agencies, and other youth-serving organizations.

Center for Local Public Health Services (CLPHS) and GHC staff participated on state steering committee with University of Missouri School of Nursing, Domestic and Sexual Violence coalitions and Robert Wood Johnson Foundation to develop intimate partner violence screening tool and coordinate training for pilot communities involving college campuses, LPHAs, and Whiteman Air Force Base.

The Injury and Violence Prevention Program has contracted with the University of Missouri, Think First Program to provide education to middle and high school students regarding head and spinal cord injuries.

/2012/Funding was discontinued for the University of Missouri Think First program.//2012//

/2013/AHP contracts with the University of Missouri include: PREP Evaluation; curriculum training for PREP; and preconception health curriculum resource development and training.//2013//

/2013/Obesity Prevention contracts with the University of Missouri Extension to meet goals for farm to institution and livable streets efforts. The funding has enabled them to hire a statewide farm to school coordinator.//2013//

Boards, Committees, and Councils

DHSS, Healthy Families and Youth (HFY) is represented on the State Interagency Coordinating Council (SICC) which advises and assists the Department of Elementary and Secondary Education (DESE) in the performance of responsibilities as stated in the IDEA Part C Program for infants and toddlers with disabilities.

HFY staff represents DHSS on the Missouri Special Quest State Leadership Team. This team, coordinated by the State Head Start Collaborative Office, has a goal to develop plans and strategies to increase inclusive opportunities for children with special needs from birth to five in early care settings.

Comprehensive System Management Team (CSMT) is responsible for the development of the children's comprehensive mental health plan for the state and the HFY Section Administrator participates on the team.

Adolescent Health Program (AHP) coordinates the statewide Council for Adolescent and School Health (CASH) and the council advises DHSS in assessing adolescent health needs and planning effective strategies to reduce health risks and promote healthy youth development. AHP is represented on school dropout prevention advisory groups. AHP Coordinator serves on the Governor's Substance Abuse Prevention Advisory Committee and the Missouri Youth/Adult Alliance.

In January 2007, the Governor appointed the first Missouri Coordinating Board for Early Childhood (CBEC). DHSS is represented on the Board and the membership of the CBEC has substantial expertise in early childhood systems; many are recognized and active at the national level and are key sources of information and networking regarding developing policy issues.

DHSS and DESE jointly participate on the State Reconvene Team with National Stakeholders Collaborative to Integrate HIV, STD, and Teen Pregnancy Prevention for School-aged Youth and the Preconception Health for Adolescents Action Learning Collaborative (ALC) to increase collaboration among state public health and education agencies on implementing evidence-based

approaches to HIV, STD, and teen pregnancy prevention and preconception health for adolescents.

The Injury and Violence Prevention Program (IVPP) coordinates the Missouri Injury and Violence Prevention Advisory Committee (MIVPAC) to address injury issues and provide guidance on injury prevention initiatives and activities. The committee is comprised of state and local public and private professionals.

/2012/MIVPAC will be expanded to form the Injury Community Planning Group (ICPG). This group will include additional public and private partners in order to identify the injury priority areas and update the state plan by developing a coordinated system, to deliver technical assistance and training to advance prevention efforts. Brown Center Injury and Violence Prevention, Washington University and St Louis University will participate in the ICPG and share their expertise.

Missouri is one of the 14 states selected to participate in Rural Injury Prevention Injury Community of Practice initiated by Children's Safety Network in addressing the rural injuries. The team members include: Center for Local Public Health Services, Office of Primary Care and Rural Health, Central Safe Kids Coalition and Children's Mercy Hospital.//2012//

/2013/The subcommittee within MIVPAC was established to assess the injury prevention activities that are supported and conducted by school nurses in Missouri and their needs for injury prevention programs. The purpose of this program is to establish baseline measures of injury prevention activities in Missouri schools.//2013//

The Adult Head Injury (AHI) Program, in the Bureau of Special Health Care Needs, facilitates the Missouri Head Injury Advisory Council (MHIAC). MHIAC is comprised of members, appointed by the Governor and the Missouri General Assembly, to represent consumers, families with a member with head injury, professionals, proprietary schools, private industry, health industry, and state agencies which administer programs regarding education, mental health, health, Medicaid, insurance, and public safety. MHIAC is advisory to DHSS and also serves in a specific advisory capacity to the Traumatic Brain Injury Implementation Partnership Grant.

The ECCS Project Director is a member of the American Academy of Pediatric Dentistry (AAPD) Head Start Dental Home Initiative (DHI) state leadership team. This partnership will help children access oral health care through the development of a national network of pediatric and general dentists who will provide quality dental homes for Head Start and Early Head Start children.

Bureau for Health Informatics (BHI) and the Title V Director actively participate on the Missouri Medicaid Managed Care Quality Assessment and Improvement Advisory Committee and BHI provides data on birth indicators to assist in evaluating and improving the health of mothers and children using Medicaid.

/2013/DHSS and CPHN identified a gap in training and networking for local public health nurses and are piloting regional trainings.//2013//

HFY is represented on the Missouri Prevention Partners (MPP) Coalition, a group of statewide public and private nonprofit organizations. The MPP mission is to provide leadership to reduce child abuse and neglect by strengthening families and communities.

Three DCPH staff represent DHSS on the Missouri Drug Endangered Children's Council, a group of statewide public and private organizations that are concerned with the issues of children who are in environments where harmful substances are used, manufactured, or distributed.

/2013/The Department is represented on two groups working to coordinate statewide obesity prevention efforts. The first is the Missouri Council for Activity and Nutrition

(MOCAN) which is a statewide coalition that serves as the main vehicle for collective, statewide obesity prevention initiatives. MOCAN is comprised of representatives from local and state-level agencies, institutions, organizations, and coalitions and individuals who work together to advance the goals and objectives of the statewide plan Preventing Obesity and Other Chronic Diseases. The second is the Missouri Convergence Partnership which serves to leverage its resources and influence to achieve significant improvements in policies and environments to support healthy eating and active living across Missouri. The Partnership is a collaboration of investors, collaborators, and advisors including health care foundations, local nutrition and activity related coalitions, University of Missouri Extension and the Department.//2013//

/2013/The Title V Director represents DHSS on the Governor's Task Force on Prematurity and Infant Mortality and the Task Force on Child Sexual Abuse.//2013//

Grants and Other Collaborations

Missouri was one of six states selected to participate in the Preconception Health for Adolescents Action Learning Collaborative (ALC) initiative with AMCHP, ASTHO, CDC, and fellow innovative states on integrating preconception health recommendations into adolescent health efforts. Missouri Team members included: DHSS' Adolescent Health Program, Office of Women's Health, and other programs; DESE Family and Consumer Sciences Education programs; Missouri Foundation for Health; and various stakeholders.

The Section for Healthy Families and Youth collaborates with the Maternal, Child and Family Health Coalition of St. Louis, the Mother and Child Coalition of Greater Kansas City, and the Missouri Bootheel Regional Consortium to implement programs and discuss issues related to the MCH population in their areas. Face to face meetings are held annually and conference calls three to four times a year in order to facilitate these efforts.

/2013/Missouri was one of the 13 states selected to participate in the Children's Safety Network (CSN) learning initiative on implementing evidence based practices into injury prevention programs. Missouri Team members include: DHSS Adolescent Health Program, School Health Program, Center for Local Public Health Agencies and Department of Mental Health.//2013//

CLPHS provided training/best practices for contractors on injury, obesity & tobacco prevention with University of MO Extension (nutrition), Children's Trust Fund, Missouri KidsFirst, SAFE Kids Coalitions and Comprehensive Tobacco Program. Staff participates in a planning committee led by the Missouri Bicycle & Pedestrian Federation on Safe Routes to Schools.

The Missouri Chapter American Academy of Pediatrics partners with DHSS to provide training and education on current adolescent health issues, immunizations, breastfeeding, and newborn health.

The Missouri American Academy of Pediatrics Early Hearing Detection and Intervention (EHDI) Chapter Champion supports the Missouri EHDI system by educating pediatricians and families on the importance of newborn hearing screening and appropriate follow-up.

Bureau for Health Informatics (BHI) assists the St. Louis University School of Public Health in sponsoring the ongoing development and training of an Evidence Based Public Health Decision Making course that emphasizes using documented data and intervention results to assist in health planning. This course is offered to DHSS and LPHA employees.

/2013/Missouri was one of 14 states selected to receive a Child Care Wellness Grant from USDA. The goals of the grant activities are to improve the nutrition and physical activity environments in child care centers by increasing the number of providers meeting specific

nutrition recommendations laid out in the Missouri Eat Smart Guidelines for Child Care and implementing "I Am Moving, I Am Learning." The Child and Adult Care Food Program (CACFP) is overseeing implementation of grant activities.//2013//

/2013/Faith-Based Initiative

New efforts began on July 1, 2012 to develop a Faith-Based Initiative for the Division of Community and Public Health. A well-known barrier to full delivery of the public health message is providing credible and consistent education in trusted settings where people make decisions for health behavior change leading to better health outcomes. Better health is a message promoted by both faith-based sites and by federal and state health entities and when these groups collaborate a synergy emerges that enhances such efforts.

The Bureau of Health Promotion works with internal preventive programs (such as heart disease, tobacco, diabetes, disaster preparedness and recovery, and cancer) to coordinate a comprehensive approach in faith-based arenas. In addition, at faith-based groups' request education and facilitation resources garnered in the bureau provide opportunities for partnership and event planning.//2013//

F. Health Systems Capacity Indicators

Introduction
While the majority of activities listed below are funded in some portion (staffing, supplies, etc.) by the MCH Title V Block Grant, there may be some which do not receive funding from the Block Grant but still impact the health systems capacity indicator.

ASTHMA:

Health Systems Capacity Indicator 01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

Narrative:
Based on the most recent air quality data, the U.S. Environmental Protection Agency has determined that all areas in Missouri meet the National Ambient Air Quality Standards for fine particles, measured over a 24-hour period. Meeting these air-quality standards is very important to protect public health, because when inhaled the fine-particle pollution can aggravate asthma as well as other chronic lung problems.

The Early Childhood Asthma Initiative in Missouri (ECAIM) is a Department of Health and Senior Services (DHSS) initiative through ARRA funding to improve the quality of childcare facilities in identifying and reducing asthma triggers. The program is improving the care of children in these facilities through asthma management education for families of these children. Progress to date includes: 1) Contracts developed for approximately 60% of the Local Public Health Agencies for either environmental assessment for childcare facilities to identify and reduce asthma triggers, and/or provision of childcare consultation services to families of children with asthma, and/or strategy development for linking childcare facilities to local, state, and national resources to address asthma; 2) On-line asthma education for childcare consultants; 3) Training for environmental specialist to provide childcare environmental assessments; and 4) Development and distribution of educational materials for childcare facilities on asthma trigger identification and reduction, management of asthma in the childcare setting and families of children with asthma on home asthma trigger identification and reduction and asthma management.

/2013/In FFY 2011 the CCHCs provided 124 hours of group education about the Management of Asthma in Young Children to 949 child care providers and 2 young

parents. In addition, 28 hours of group education on Environmental Triggers in Child Care Centers (Indoor Air Quality) was provided to 232 child care providers. A total of 62 child care providers received one-on-one consultation regarding asthma management and 14 asthma action plans were put in place.//2013//

/2013/Through the American Recovery and Reinvestment Act, the MO Asthma Prevention and Control Program (MAPCP) received $2 million to address asthma in licensed child care facilities statewide through a Memorandum of Understanding with the MO Department of Social Services. The Early Childhood Asthma in MO (ECAIM) Initiative provided environmental specialists in LPHAs with training and equipment to perform indoor air quality assessments for licensed child care facilities, families with information on home indoor air quality and asthma management, and child care health consultants with educational materials, on-line training, and tools to provide education to families of pre-school children with asthma. Easy to use assessment tools and forms were created to capture information from parents of children with asthma before and after education. On-line training and assessment tools allowed DHSS to rapidly deploy and evaluate the intervention. Results indicated there were significant increases in children having no days of disruption in routines and no nights of being awakened from asthma symptoms. Two out of three parents/caregivers felt the asthma education helped them better care for their child's asthma. In a survey question to the facilities relating to the greatest needs of young children with asthma and their parents/caregivers, the most common need reported was for better education about why asthma occurs and how to manage it. Another common concern was reducing the child's exposure to environmental triggers, especially secondhand smoke in the home, and that children need to be more knowledgeable of their own triggers, medications and emergency action plans.//2013//

/2013/Camp Catch-Ya-Breath was established in 2012 through a partnership between University of Missouri Respiratory Therapy Program and Washington County Memorial Hospital in Potosi, MO. Camps were held in June 2012 in two locations on different dates. The objective of the camps is to help children with asthma take control and live life to its fullest. Respiratory therapists, physicians and nurses teach children about asthma, avoiding triggers, how to take medications properly and how to follow an asthma action plan.//2013//

The School Health Services Contract has a performance measure related to case management of a child with a special health care need or a chronic condition. Establishment of an Asthma Action plan is one component of this. These contracts reach both the preschool and school age populations.

/2013/Funding for the School Health contract was eliminated.//2013//

INFANT SCREENING:

Health Systems Capacity Indicator 02: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Health Systems Capacity Indicator 03: The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

Narrative:
/2013/The MCH Home Visiting programs served 1,021 women in 2011 (546 in the MCBHV program and 475 in the BB.) Beginning in 2011 only pregnant women could enroll in the MCBHV program with the goal being to enroll 50% multiparous women. The Home Visitors educate their clients on the frequency and need for well child check-ups including benefits

of and immunization schedule. The immunization rate for infants at age two was 92.5% for those enrolled in these programs.//2013//

/2013/In FFY 2011, 31,897 Baby Your Baby Keepsake Books in English and 2,545 books in Spanish were distributed statewide.//2013//

Special Health Care Needs (SHCN) Programs collaborate with other state agencies and local communities to identify and help enroll children in Medicaid. The Children and Youth with Special Health Care Needs Program (CYSHCNP) and the Healthy Children and Youth (HCY) Program provide service coordination for children from birth to age 21. Service coordination includes providing resources to obtain necessary services, including periodic screenings.

PRENATAL CARE:

Health Systems Capacity Indicator 04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Health Systems Capacity Indicator 05C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Health Systems Capacity Indicator 05D: Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

Narrative:
The Missouri Community-Based Home Visiting and Nurse Family Partnership (Building Blocks of Missouri) Home Visiting programs educate their clients on the importance of early entry into and adequacy of prenatal care, and assure all women enrolled in their programs are getting prenatal care. Clients are assisted with finding a prenatal care provider if they do not have one when enrolling in the program and on applying for Medicaid\SCHIP to have a payment source for prenatal care. Home visiting staff continually work with their clients to assure they have made and keep follow-up appointments with their prenatal care providers to assure adequacy of prenatal care. Since clients can enroll in these programs up to 28 weeks gestation sometimes they are past the first trimester when enrolling. Data are collected on all women enrolled in the programs on entry into prenatal care.

The Medicaid Managed Care plans reach this population and provide specific interventions such as case management.

/2013/Nine LPHAs are addressing adverse birth outcomes in FFY12-14. Majority are focusing on teen pregnancy by providing STD screening/prevention, prenatal/perinatal nutritional counseling, early entry into prenatal care, smoking cessation and low birth weight by working with schools, parents and civic groups, and faith-based organizations to increase awareness and knowledge on prevention.//2013//

TEL-LINK, the toll-free information and referral line for MCH services, connects pregnant women to prenatal referrals and other services such as Medicaid and WIC. The TEL-LINK website links with the Baby Your Baby website.

The TEL-LINK program collaborates with WIC and Nutrition Services by listing the TEL-LINK number on WIC posters throughout the state for women to call. Promotion of the TEL-LINK program is done through exhibits at various health fairs and conferences, advertising in parenting and health magazines, mailing of the TEL-LINK brochure to Missouri families, state and public agencies, and collaboration with other maternal and child health programs.

/2013/LPHAs provide counseling and referral for pregnant women, risk appraisals and

prenatal case management, screen for Temporary Medicaid (TEMP) eligibility, provide coverage document and referral to FSD for application for global prenatal care and delivery, referrals for appointments with local/regional OB providers.//2013//

DENTAL:

Health Systems Capacity Indicator 07B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Narrative:
Through the School Health Services Contracts from 1995 to present, the percent of children with a dental exam within the past 12 months increased from 16% to 66%.

Oral Health Program collaborates with many partners to integrate the Preventative Services Program (PSP) into new communities. With the 2009-2010 school year yet to be completed, over 49,000 children have already received an open mouth screening, fluoride varnish application and oral health education.

/2013/During the 2010-2011 school year 64,657 children participated in PSP offered in 549 schools, child care centers, clinics, etc.//2013//

Local Child Care Resource and Referral (CCRR) staff provide oral health training to child care providers as part of Basic Child Care Orientation Training supported by the Department of Health and Senior Services (DHSS) and the Department of Social Services (DSS).

/2013/The CCHC Program provides clock hour training, consultation and health promotions (directed at children) on topics related to health and safety, upon request, to child care providers and children enrolled in child care.//2013//

Medicaid Managed Care programs also focused on a dental care Performance Improvement Project which included: providing a separate dental handbook for members, "Floating" Dentists (dentists rotate through rural sites), partnering with Community Events to promote the importance of dental care, collaborate with schools and School Nurses, encourage dentists to have weekend and evening hours for appointments, providing mobile dental services, Dental Prescriptions (PCP hands the parent/teen a prescription for a dental exam which has information numbers about where to call to make appointments), incentives used to get children and adolescents to exams, public relations campaigns for outreach, "Give Kids A Smile" program at the Dental School in KC or partner with the MO Dental Association, paying higher reimbursement rates for dentists who see a certain number of members within a certain period of time, paying higher rates for Pediatric Dentists, and reminder calls to members who have not had a dental claim submitted on them in the last 6 months.

/2013/18 LPHAs assist with dental services in their communities.//2013//

SHCN:

Health Systems Capacity Indicator 08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Narrative:
Collaboration among Special Health Care Needs (SHCN) Programs, other state agencies and local communities help to identify and enroll children in Missouri's SCHIP and Medicaid.

The Children and Youth with Special Health Care Needs Program (CYSHCNP) and the Healthy Children and Youth (HCY) Program provide service coordination for children from birth to age 21. Service coordination assists families in obtaining necessary services, including referrals to SSI.

SHCN has an agreement with the Disability Determination Unit (DDU) to refer children who apply for SSI to SHCN regional offices.

LOW BIRTHWEIGHT:

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

Narrative:
The Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program and the Missouri Community-Based Home Visiting Program provide education to pregnant women on tobacco use preconceptually and throughout pregnancy to decrease the incidence of preterm births; need for adequate prenatal care, and birth spacing less than 18 months apart to decrease the incidence of preterm births.

Medicaid Managed Care programs focus on a variety of Performance Improvement Projects which includes hi-risk OB care. This has been a focus for all plans on an on-going basis. Activities include case management, peer-to-peer educational baby showers, and specialty care (such as gestational diabetes, history of premature labor, pregnancies to those age 17 and under).

/2012/Text4baby messages include those on not smoking during pregnancy and services available to quit smoking, proper nutrition including information on food pantries and WIC, not using drugs during pregnancy and referrals to quit drug use, birth spacing, and need for early and regular prenatal care including how to find a healthcare provider and enroll in Medicaid.//2012//

/2013/LPHAs addressing low birth weight through contracts with the MCH Services Program focus on adolescent population, risk and protective factors, and improving maternal health behaviors.//2013//

/2013/The MO Hospital Association has developed a Hospital Engagement Network (HEN) focused on reducing early elective deliveries (EEDs). Nearly 25% of Missouri's birthing hospitals and several local and state agencies are represented in this collaborative effort to reduce EEDs. Several of these hospitals have adopted the policy that no EEDs will be scheduled prior to the 39th week of pregnancy, and some have maintained a 0% EED rate for the past 4-5 years.

In October 2011, birthing hospitals in the St. Louis metropolitan area were awarded a grant by the Midwest Health Initiative to reduce early elective deliveries. Collaborating with the business community, these health care providers are achieving success in their efforts to reach 0% early elective delivery rates.

Centering Pregnancy is a healthcare delivery method in which pregnant women receive their prenatal care in a group setting, offering support and education to one another. This practice has been found to reduce the mother's rate of premature delivery and is currently in place in St. Louis, Kansas City, Ste. Genevieve and Springfield, with several other sites in planning for this transition.//2013//

INFANT DEATHS:

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

Narrative:
/2013/An MOU was signed between the Maternal Child Family Health Coalition who runs Triumph and the Myrtle Hilliard Davis Health Center (an FQHC). Triumph will provide a voucher for a free prenatal visit to any pregnant woman in the community in order to reduce the women's fears that prenatal care is too expensive. Myrtle Hilliard Davis will refer all pregnant clients to Triumph support groups in order to increase prenatal visit compliance. A community awareness event in March was attended by 102 adults and 81 children. Pregnancy tests were distributed at this event.

A $10,000 pro bono advertising award was received from the Standing Partnership and additional funding was received from the Dohmen Foundation.//2013//

/2013/The MIECHV Grant provides Early Head Start and Parents as Teachers programs to families in Pemiscot, Dunklin, Butler, Ripley and Jasper counties. These programs are currently serving 201 families with the ability to serve an additional 43 families in the near future. The Nurse Family Partnership program is operational in St. Louis, Kansas City, Cape Girardeau and recently expanded to Pemiscot and Dunklin counties. This program utilizes Registered Nurses to make home visits to first time pregnant women beginning at least at their 28th week of pregnancy through age two of the child. Research has shown this program reduces the infant mortality rate among participating infants.//2013//

The Bureau for Genetics and Healthy Childhood (GHC) has contracts with the Maternal, Child and Family Health Coalitions of St. Louis and Greater Kansas City to implement a Fetal and Infant Mortality Program based on the national model established through the American College of Obstetrics and Gynecology.

/2013/The FIMR contracts with the Maternal, Child and Family Health Coalitions were discontinued 9/30/11. The agencies continue to implement FIMR through an agreement with the Bureau of Vital Statistics to obtain birth and death certificates.//2013//

A Public Health Consultant Nurse from the GHC and Local Public Health Agencies (LPHAs) serve as members of the State Child Fatality Review team. The team meets at least two times per year to review data concerning deaths of children from the age of one week to 18 years of age. Prevention efforts are then targeted based on the trends shown through the review process.

/2013/All LPHAs have staff who participate in their Local Child Fatality Review Board. The Board convenes whenever there is a child death in their jurisdiction.//2013//

/2013/LPHAs (95) provide safe sleep practices education; 86 have child passenger seat programs; 40 conduct newborn home visits; 36 conduct prenatal home visiting.//2013//

The Building Blocks of Missouri (Missouri's Nurse Family Partnership) Nurse Home Visiting Program and the Missouri Community-Based Home Visiting Program provide education to pregnant and parenting women on the importance of providing a safe sleep environment for their infants.

Beginning April 2010, GHC will provide portable cribs and safe sleep education delivered through LPHAs to decrease the number of deaths to infants related to unsafe sleep practices including bed-sharing. The cribs will be provided free of cost to low income families.

/2013/Through FFY 2011 the program has distributed 558 cribs and completed 1,116 safe sleep educational visits.//2013//

/2012/The program has continued with additional funding from the Children's Trust Fund, the Emergency Medical Services Block Grant and the MCH Title V Block Grant.//2012//

/2012/In FFY2010, the CCHC program provided 163 hours of training on safe sleep, 89 hours of injury prevention training/consultation and 475 hours of First Aid/CPR training for child care providers.//2012//

/2013/In FFY2011, the CCHC Program received funding through American Recovery and Reinvestment Act (ARRA) to conduct training/consultation with child care providers on safe sleep, during which 896 providers and 20 parents received 189 combined hours of training/consultation. ARRA funds were expended in August 2011, yet the CCHCs will continue to provide training upon request regarding safe sleep. Additionally, 73 hours of combined training/consultation and 215 children's health promotions were conducted on injury prevention; and 547 hours of training/consultation and 10 children's health promotions were conducted on First Aid/CPR/ER Preparedness. Due to recent rule changes, First Aid/CPR requests for training have increased.//2013//

STATE'S MEDICAID AND SCHIP:

Health Systems Capacity Indicator 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Narrative:
Collaboration among Special Health Care Needs (SHCN) Programs, other state agencies and local communities help to identify and enroll children in Missouri's SCHIP and Medicaid. Service coordination within Children and Youth with Special Health Care Needs Program (CYSHCNP) and Healthy Children and Youth (HCY) assists families in obtaining necessary services for children from birth to age 21, including navigation of the Medicaid system.

Child Care Health Consultants (CCHC) program distributes information and provides education to child care providers and parents of young children regarding the availability of Medicaid.

The Child Care Resource and Referral Network (CCRR) provides statewide services for families and CYSHCN needs through eight local agencies. Qualified inclusion staff are located in each CCRR agency to provide statewide-enhanced services. All eight local agencies maintain toll-free phone numbers. Families may call and seek referrals to child care programs. Referral Specialists collect data such as: immunization status of children, health issues including diseases and birth defects, developmental issues, and insurance status of children. Inclusion staff assist with development of a plan of action, in collaboration with the family, to support child care services to CYSHCN; provide coordination services to accommodate CYSHCN by working with families, child care homes and centers, and other agencies serving the child; and referral of all families of CYSHCN to the IDEA Part C (First Steps) Program, local Public School District or other appropriate programs or services.

/2012/Effective July 1, 2010, Section for Child Care Regulation (SCCR) no longer contracts with CCRR to provide referrals, however the Inclusion Specialist contract remains active. Additionally, effective October 1, 2011 CCRR now has four local agencies due to consolidation and is called Child Care Aware of Missouri.//2012//

Medicaid Managed Care programs focused on young child and adolescent health Performance Improvement Projects to increase EPSDT screens. The number of EPSDT well child/youth screenings rose from 33% in 2006 to 35.9% in 2009.

/2012/The School Health Program provides resources, webinars and regional workshops for school nurses on how to assist families to enroll in Medicaid. Additionally, the state school nurse consultant is working with agencies and school districts to develop guidance to assist school districts to bill for private duty nursing services for Medicaid-eligible students with an Individualized Education Program.//2012//

Health Systems Capacity Indicator 06A: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)

Narrative:
The Medicaid program in Missouri provides health insurance coverage for children under age 1 whose net family income does not exceed: 185% of Federal Poverty Level (FPL). Under SCHIP that coverage is expanded 300% of FPL. The SCHIP program provides the same health services as those covered under Medicaid, except that SCHIP children and youth are not eligible for non-emergency medical transportation. Based on an income scale, some individuals covered under Missouri's SCHIP program must pay premiums. Premiums paid per family per month range from $13 to $277.

Health Systems Capacity Indicator 06B: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children

Narrative:
The Medicaid program in Missouri provides health insurance coverage for children whose net family income does not exceed: 133% of Federal Poverty Level (FPL) for children ages 1 to 5 and 100% of FPL for youth ages 6 to 18. Under SCHIP that coverage is expanded to 300% of FPL. The same limitations and premium levels apply as stated in Health Systems Capacity Indicator 06A.

Health Systems Capacity Indicator 06C: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women

Narrative:
Pregnant women with family incomes up to 185 percent of Federal Poverty Level (FPL) qualify for Medicaid coverage under the MO HealthNet for Pregnant Women (MPW) program. Qualification under this category includes 60-day postpartum coverage even with subsequent increases in family income.

TEL-LINK, the toll-free information and referral line for MCH services, connects Missourians to a wide range of services including Medicaid.

MCH Program Access:

Health Systems Capacity Indicator 09A: The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

Narrative:
Bureau of Health Informatics (BHI) is responsible for vital statistics system; maintains various health-related databases; performs linkages between program and vital statistics data; provides data for program evaluations from applicable vital statistics files; collaborates with such entities as MO HealthNet regarding MCH indicators for Medicaid managed-care population; provides support for Missouri Child Fatality Review program; produces health indicators from linked birth-PAS data systems; links Statewide Traffic Accident Records Systems (STARS) motor vehicle crash data to hospital inpatient and emergency room data and death certificate data; and provides data support to private organizations such as March of Dimes and MCH researchers at universities nationwide. BHI assisted in developing a web-based birth registration system utilizing the 2003 national birth certificate. This version collects additional information such as multiple races and ethnicities, clearer recording of birth defects, maternal smoking behavior and mother's

weight at the end of her pregnancy. The Vital Statistics system follows National Center for Health Statistics (NCHS) guidelines regarding collection and analysis of race and ethnicity data. Missouri will be implementing the State and Territorial Exchange of Vital Events (STEVE) System. STEVE is an innovative messaging application developed by NAPHSIS for the electronic exchange of vital event data between jurisdictions. STEVE replaces the current, less secure practice of exchanging paper copies, line lists and printed computer abstracts.

/2013/Missouri has implemented an installation of the STEVE system as of February 2011. Missouri currently receives many other jurisdictions' vital records data for Missouri residents via STEVE's secure electronic messaging. In addition Missouri has recently started to transmit Missouri vital records to other jurisdictions for their residents.//2013//

TOBACCO:

Health Systems Capacity Indicator 09B: The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.

Narrative:
By combining forces with the Missouri Foundation for Health (MFH) and state advocacy groups, approximately 230 schools or youth groups around the state are now working on changing their communities' norms around tobacco use. Youth advocacy\prevention groups include Smokebusters and Youth Empowerment in Action Tobacco Education, Advocacy, and Media (YEA TEAM). Smokebusters is high school based and YEA TEAM is middle school based. Smokebusters started in northeast Missouri in 1999 and became active in 2005 on a limited basis in the northwest, southeast and southwest. The state funding in 2008-2011 has allowed the program to spread to Kansas City and western Missouri and to more counties in the southwest. The YEA TEAM program started in the St. Louis area and the southeast in 2006. State funding from 2007-2011 has allowed the program to spread to more schools in the St. Louis area.

/2012/Using the 2011 update survey, the School Health Program collected baseline data from 85% of the total student population related to school policies regarding smoke free campuses, buildings, and smoking cessation classes for staff or students. This information will be used for program planning.//2012//

/2013/LPHA contractors with MCH Services Program continue to collaborate with local schools and communities to provide avoidance and cessation education through various programs, second hand smoke campaigns, and assistance with development of ordinances and policies in collaboration with state tobacco staff.//2013//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Missouri Title V Block Grant Performance Measurement System follows the MCHB system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. After the priority needs are established by the five-year statewide needs assessment, resources are assigned and program activities implemented to specifically address these priorities. State Performance Measures are then developed to supplement the National Performance Measures, Health Systems Capacity Indicators, Health Status Indicators, and National Outcome Measures. Progress is monitored by tracking each of these performance measures. Both budgeted dollars and expenditures are categorized and tracked across the four service levels in the MCH Pyramid: direct health care services, enabling services, population-based activities, and infrastructure-building activities. Because of the flexibility available with these funds the role the Title V agency plays in each performance measure may be different. The Life Course perspective was used as a framework for developing the state's performance measures. Missouri's view of the Life Course perspective is that it could not be encompassed in a specific priority or performance measure, but was the overarching theme use for the development of the state performance measures.

See Section II, Needs Assessment, for further details.

See Table 4b in D. State Performance Measures of Section IV Priorities, Performance and Program Activities and Form 16, State Performance Measure Detail Sheets, for descriptions of the state selected measures that includes their category on the pyramid, the Missouri goal, the measure used, how the measure is defined, the measure's relationship to Healthy People 2010 (if applicable), data sources and data issues and the significance of the indicator or why this particular indicator was chosen.

An attachment is included in this section. IVA - Background and Overview

B. State Priorities

As a part of the 2010 Five Year Needs Assessment process, Missouri identified ten MCH State Priority Needs. The National and State Performance Measures as they relate to Missouri's MCH State Priority Needs are shown below. The capacity of the state's Title V program related to the performance measures are discussed in the respective performance measure narrative.

1. IMPROVE HEALTH CARE ACCESS FOR MISSOURI MCH POPULATIONS

The performance measures related to this priority are:

SPM 10: Percent of children ages 0-19 years old who received health care at a FQHC.

NPM 2: The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. (CSHCN survey)

NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN survey)

NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN survey)

NPM 5: The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily. (CSHCN Survey)

NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)

NPM 13: Percent of children without health insurance.

NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

2. PREVENT AND REDUCE SMOKING AMONG MISSOURI WOMEN AND ADOLESCENTS

The performance measures related to this priority are:

SPM 1: Percent of women aged 18-44 years who are current cigarette smokers.

SPM 2: Percent of cigarette smoking among high school students.

NPM 15: Percentage of women who smoke in the last three months of pregnancy.

3. REDUCE OBESITY AMONG MISSOURI WOMEN, CHILDREN AND ADOLESCENTS

The performance measures related to this priority are:

SPM 3: Percent of mothers who are prepregnancy overweight by 20% or more.

SPM 4: Percent of high school students who met currently recommended levels of physical activity.

NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services that have a Body Mass Index (BMI) at or above the 85th percentile.

4. IMPROVE THE MENTAL HEALTH STATUS OF MCH POPULATIONS IN MISSOURI

The performance measure related to this priority is:

SPM 8: Percentage of women with a recent live birth who reported frequent postpartum depressive symptoms.

5. ENHANCE ACCESS TO ORAL HEALTH CARE SERVICES FOR MISSOURI MCH POPULATIONS

The performance measures related to this priority are:

SPM 6: Percentage of women aged 18-44 who visited a dentist or a dental clinic for any reason within the past year.

NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

6. IMPROVE PRECONCEPTION HEALTH AMONG MISSOURI WOMEN OF CHILDBEARING AGE

The performance measure related to this priority is:

SPM 7: Percentage of women with a recent live birth who reported taking a multivitamin or a prenatal vitamin four or more times per week in the month prior to pregnancy.

7. REDUCE THE RATE OF TEEN PREGNANCIES AND BIRTHS IN MISSOURI

The performance measures related to this priority are:

SPM 5: Birth rate (per 1,000) among teenage girls aged 15-19 years.

NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

8. REDUCE DISPARITIES IN ADVERSE BIRTH AND PREGNANCY OUTCOMES

Two National Outcome Measures are used to measure the performance towards this priority. They are:

NOM 1: Infant mortality rate per 1,000 live births.

NOM 2: Ratio of the black infant mortality rate to the white infant mortality rate.

9. REDUCE INTENTIONAL AND UNINTENTIONAL INJURIES AMONG WOMEN, CHILDREN AND ADOLESCENTS IN MISSOURI

The performance measures related to this priority are:

NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

NPM 16: The rate (per 100,000) of suicide deaths among youths 15-19.

10. SUPPORT ADEQUATE EARLY CHILDHOOD DEVELOPMENT AND EDUCATION SERVICES IN MISSOURI

The performance measures related to this priority are:

SPM 9: Percent of infants with permanent hearing loss and enrolled in appropriate early intervention services that are enrolled in those services by 6 months of age.

NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for conditions(s) mandated by their state-sponsored newborn screening programs.

NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

NPM 11: The percent of mothers who breastfeed their infants at 6 months of age.

NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	96.2	98.6	100.0	94.2	100.0
Numerator	101	139	165	146	129
Denominator	105	141	165	155	129
Data Source		DHSS Bureau of Genetics and Healthy Childhood.	DHSS Bureau of Genetics and Healthy Childhood.	DHSS Bureau of Genetics and Healthy Childhood.	DHSS Bureau of Genetics and Healthy Childhood.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011
MO DHSS Bureau of Genetics and Healthy Childhood. Final calendar year 2011 data.

Notes - 2010
Source: MO DHSS Bureau of Genetics and Healthy Childhood. Final calendar year 2010 data.

Notes - 2009
Source: MO DHSS Bureau of Genetics and Healthy Childhood. Final calendar year.

a. Last Year's Accomplishments
Established a Newborn Screening for Lysosomal Storage Disorders (LSD) Task Force to assist the NBS Laboratory and NBS Follow-Up program in establishing laboratory cut-offs, disorders screened, etc.

Newborn Screening (NBS) Sample Storage Process was implemented on July 1, 2011. Missouri law requires the State Public Health Laboratory (SPHL) to retain the NBS samples for five years after testing has been completed and destroy after the five years of storage has ended. The law allows for the SPHL to release the samples for anonymous research. The law also provides three opt-out/dissent options for the parents or legal guardians if they do not want their child's leftover NBS sample for anonymous research. These options are: return the leftover sample to the parents; destroy the leftover sample in a scientifically acceptable manner; or store the leftover

sample for five years but don't release for anonymous research.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screen all newborns born in Missouri for mandated metabolic and genetic disorders.			X	
2. Contract with four genetic tertiary centers to track and follow-up on babies with abnormal screen results.		X		
3. Contract with three pediatric hemoglobinopathy centers to provide follow-up for confirmatory testing for conditions detected through the newborn screening program.		X		
4. Contract with four accredited cystic fibrosis (CF) centers to track and follow-up on babies with abnormal CF screen results.		X		
5. Provide notification to parents of newborns identified with hemoglobin traits via letter and fact sheet about the identified trait condition.		X		
6. Missouri is continuing to work with Heartland Regional Genetics & Newborn Screening Collaborative to develop a genetic services assessment tool to assure adequate and quality services are provided.				X
7. Developed policies and procedures to approve requests for NBS specimens for research purposes.			X	
8. Developed a customized Text4baby message addressing the need for families to follow-up with their infant's physician to assure newborn screening is completed and to make sure they are aware of the result.			X	
9. Send letters to parents whose baby had a "poor quality specimen" that could not be tested to request that they have a repeat screen done.		X		
10.				

b. Current Activities

All activities listed in Table 4a will be continued.

The Newborn Screening Laboratory began screening newborns for cystic fibrosis using IRT/DNA on July 1, 2012.

Developed ACTion (ACT) Sheets included in the notification by the State Public Health Laboratory (SPHL) sent to the physician on positive newborn screen results (NBS) for Sickle Cell disease, hemoglobin SC disease and hemoglobin S/beta thalassemia. The ACT sheets describe the short term actions a health professional should follow in communicating with the family and determining the appropriate steps in the follow-up of the infant that has screened positive for these three disorders.

See Form 6. All newborns with a confirmed diagnosis received treatment with the exception of one who died prior to the initiation of treatment.

c. Plan for the Coming Year

All activities listed in Table 4a will be continued.

A pilot test to screen for Gaucher, Fabry, Hunter, Hurler, and Pompe will begin in January 2013 with the expectation that these five lysosomal disorders (LSDs) will be added permanently to the newborn screening (NBS) panel by July 1, 2013. When these five LSDs are permanently added to the NBS panel, a pilot to screen for severe combined immunodeficiency (SCID) will begin in the summer of 2013 with it being added to the NBS panel in 2014. Pilot testing for Krabbe is on schedule to begin January 2013. Niemann-Pick will be added to the NBS panel when these assays become validated.

Contracts with the adult and pediatric hemoglobinopathy centers, genetic tertiary centers, and accredited cystic fibrosis foundation centers will be continued for follow-up and treatment.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**73397**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	75974	103.5	13	9	9	100.0
Congenital Hypothyroidism (Classical)	75974	103.5	52	43	43	100.0
Galactosemia (Classical)	75974	103.5	16	2	2	100.0
Sickle Cell Disease	75974	103.5	27	20	20	100.0
Biotinidase Deficiency	75974	103.5	15	8	8	100.0
Cystic Fibrosis	75974	103.5	112	16	16	100.0
Organic Acid Disorders	75974	103.5	25	7	7	100.0
Amino Acid Disorders (excluding PKU)	75974	103.5	10	2	2	100.0
Fatty acid Disorders	75974	103.5	41	16	15	93.8
21-Hydroxylase Deficient Congenital Adrenal	75974	103.5	23	7	7	100.0

Hyperplasia						

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	57.2	64.5	64.7	64.9	65.1
Annual Indicator	64.1	64.1	72.5	72.5	72.5
Numerator					
Denominator					
Data Source		NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	72.7	72.7	72.9	72.9	72.9

Notes - 2011
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

The 2009-2010 percentage 72.5% in Missouri was close to the 60th percentile state level and slightly higher than the national figure of 70.3%.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010.

Notes - 2009
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010.

a. Last Year's Accomplishments
The School Health Program sponsored trainings for school nurses on developing Individualized Health Care Plans and 504 plans for children with special health care needs. The plans are developed in partnership with the family, student, health care providers and school staff.

In FFY 11 the Child Care Health Consultation (CCHC) program provided 19 hours of on-site consultation, 3 phone consultations, 140 hours of adult group training to 848 child care providers,

and 15 parents of children enrolled in child care regarding the care of children with special health care needs; 7 individualized health plans were completed.

In FY 2011 families and professionals partnered in decision making while learning how to advocate for the best possible care and resources for their children. The Family Partnership held 7 regional meetings with 166 parents and professionals in attendance. Topics included Missouri Guardianship: Understanding your Options and Alternatives, Community Connections, Networking with other families.

The Children and Youth with Special Health Care Needs Program and the Healthy Children and Youth Program served a total of 3,377 participants and families in FY 2011. The Service Coordination Assessment (SCA) includes components consistent with Federal data collection regarding participants/families reporting partnering in decision making. The Service Coordination Assessments were completed with program participants /families.

In cooperation with the key stakeholders, the Family to Family Health Information Center grant developed diagnosis specific packets on the following topics: Fetal Alcohol Syndrome, Dysgraphia, Spina Bifida, Bipolar Disorder, Cleft Lip/Palate, Asthma, and Cystic Fibrosis. Integrated Community Services Grant ended May 31, 2011. The activities related to this grant have been sustained through the Family to Family Health Information Center grant.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. School Nurse Trainings to develop Individualized Health Care Plans for children with special health care needs.	X	X		X
2. Child Care Health Consultation and training to child care providers and parents of children enrolled in child care, related to the care of children with special health care needs.		X	X	X
3. SHCN contracts for assistive technology.	X	X		X
4. Various activities to assure culturally competent services for SHCN participants/families, including utilizing professional interpreters, translating materials, and participating in events to increase knowledge of cultural diversity.		X		X
5. SHCN Family Partnership Initiative (support network for family members) and participation in family focused coalitions; Family Partners conduct outreach to increase participation; Family members provide input on special needs issues.		X		X
6. Recruited SHCN providers and distributed the Provider Fact Sheet.		X		X
7. Professional development activities for SHCN staff and staff of contracted agencies.		X		X
8. SHCN service coordination for CYSHCN including assessments, service plans, transition plans, and emergency preparedness.		X		X
9. SHCN collaborates with the following grant initiatives: Family to Family Health Information Center, Autism Spectrum Disorder, and Pediatric Care Coordination Grant.		X		X
10. SPECIAL HEALTH SERVICES facilitation of the Missouri Brain Injury Advisory Council and the Traumatic Brain Injury Grant.		X	X	X

b. Current Activities

All activities listed in Table 4a will be continued.

The School Health Program continues to offer workshops on developing individualized health care plans for students with special health care needs in the school setting. The workshops include working with parents and other providers.

CCHC program continues to offer training and consultation to child care providers regarding children with special health care needs. Assistance is available through consultation to develop individualized health plans for these children and make appropriate community referrals when indicated.

The Family to Family Health Information Center grant is developing additional diagnosis specific packets on the following topics: Infantile Cerebral Palsy, Epilepsy/Other Convulsions, Hearing Loss, Cardiac Anomalies, and Scoliosis. Family Partnership conducted a webinar including the following topics: Systems Overview of the Family to Family Health Information Center, Medical Home, and other ways to involve families. The University of Missouri -- Kansas City (UMKC) in conjunction with Special Health Care Needs (SHCN) received a grant award: Enhancing Pediatric Care Coordination for CYSHCN Through Parent-to-Parent Mentoring to enhance care coordination for urban families with children and youth with special health care needs through integration of a parent-to-parent model of peer support within pediatric care clinics. The grant period is September 1, 2011 through August 30, 2014.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

The School Health Program will continue to offer workshops for school nurses serving as care coordinators on developing individualized health care plans for students with special health care needs in the school setting. The workshops include working with parents and other providers.

The Family Partnership will continue to offer trainings and conferences for families to be able to share and network with each other. The trainings will be held throughout the state. The SHS statewide meeting will include discussions related to guardianship, medical home and transitions.

CCHCs will facilitate communication and understanding between child care providers, parents and the health care community regarding care of children with special health care needs. CCHCs, upon request, will provide group training and consultation on the general topic of inclusion of children with special needs in child care and on specific topics such as asthma, diabetes, and seizure disorders. CCHCs will assist child care providers in the development of individualized health plans (IHPs) for children in the child care setting and make referrals to appropriate health care providers as indicated.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	61.6	52.2	52.4	52.6	52.8
Annual Indicator	51.8	51.8	44.9	44.9	44.9
Numerator					
Denominator					
Data Source		NS-	NS-	NS-	NS-

		CSHCN	CSHCN	CSHCN	CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	47	47	50	50	50

Notes - 2011
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.
The 2009-2010 percentage 44.9% in Missouri was close to the 60th percentile state level and slightly higher than the national figure of 43.0%.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010.

Notes - 2009
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010.

a. Last Year's Accomplishments
Special Health Care Needs (SHCN) ensured coordinated ongoing comprehensive care for program participants through service coordination. The Service Coordination Assessments (SCA) contain criteria to identify whether the participant has a medical home, consistent with the Maternal and Child Health Bureau definition of medical home. If it was determined the participant did not have a medical home, educational materials were provided to the family to ensure coordinated, ongoing, comprehensive care for SHCN participants. In FY2011 92% of SHCN participants reported they have a medical home.

In FY2011 Special Health Services (SHS) distributed approximately 700 Medical Home Fact Sheets to Missourians through conferences and educational events.

Families who participated in the SHCN Family Partnership Parent and Caregiver Retreat received information regarding coordinated, ongoing, comprehensive care, as medical home was an agenda item of the retreat. There were 105 attendees at the retreat.

Through the Family to Family Health Information Center grant, training was provided to family members of children with special health care needs regarding the benefits of having a medical home and strategies for creating and supporting a medical home. Though the ICS Grant ended May 31, 2011 activities related to this grant were sustained through the Family to Family Health

Information Center grant.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CCHC program conducted training and consultation to child care providers and young parents of children in child care regarding elements of comprehensive, coordinated care.		X	X	X
2. Service coordination for SHCN participants, including Service Coordination Assessment.		X		X
3. Statistical data collection regarding SHCN participants who report receiving care in a medical home.				X
4. Special Health Services (SHS) promotion of medical home through education/training opportunities and distributing the Medical Home Fact Sheet.		X		X
5. SHCN collaborates with the following grant initiatives: Family to Family Health Information Center, Autism Spectrum Disorder and Pediatric Care Coordination Grant.		X		X
6. MO Managed Care Plans conducting pilot to implement patient-centered medical homes.	X			
7. MO FQHCs implementing the Medicaid Health Home concept.	X			
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4a will be continued.

MO Medicaid Managed Care Plans are working on a Patient Centered Medical Home Initiative. One plan in Kansas City is conducting a pilot involving 13 practices with over 130 physicians to implement new technologies and processes to improve patient access and care outcomes, increase patient and physician satisfaction and reduce errors.

30 Primary Care Practices at FQHCs are implementing Medicaid's Health Home concept which makes them eligible to receive up to 50% of what they save.

The Family to Family Health Information Center partnered with the Children's Mercy Hospital Medical Home Team (CMH) to develop a series of Medical Home Technology and Education Training Modules. The purpose of the training modules is to provide introductory information for extended family members and service providers who will be caring for CYSHCN. Topics for training modules include: NICU Graduates, Care of the Tube-Fed Child, Care of the Child with Chronic Lung Needs, Rehabilitation Care, Dialysis, Asthma, and Ventilator Care. The training modules are available online in addition to a DVD format that families can take home.

Family Partnership hosted a webinar focused on promoting medical home for families of CYSHCN.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

The School Health Program will continue to offer workshops for school nurses on the principles of

care coordination for children with special health care needs.

The Family to Family Health Information Center will be focusing on strategies to get more involvement at the system's level to assist with maneuvering through the complexity of coordinating all aspects of medical home.

The Special Health Services (SHS) statewide meeting will provide information for Service Coordinators to assist families in receiving coordinated, ongoing, comprehensive care within a medical home. SPECIAL HEALTH SERVICES will continue to attend conferences and educational events distributing the Medical Home Fact Sheets to Missourians.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	69	64.8	64.8	64.9	65
Annual Indicator	64.8	64.8	62.7	62.7	62.7
Numerator					
Denominator					
Data Source		NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	64	64	65	65	66

Notes - 2011
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

The 2009-2010 percentage 62.7% in Missouri was close to the 65th percentile state level and slightly higher than the national figure of 60.6%.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010.

Notes - 2009

Indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by HRSA and CDC, 2009-2010.

a. Last Year's Accomplishments
The School Health Program sponsored sessions for school nurse on how to assist parents to enroll in Medicaid. Outreach information and posters were sent to every school nurse in Missouri.

Special Health Care Needs (SHCN) administered the Children and Youth with Special Health Care Needs (CYSHCN) Program which provides early identification and health services and includes service coordination, diagnostic and treatment services involving medical care, hospitalization and aftercare to participants who require sub-specialty, specialty, preventive and primary care. Medicaid referral or verification of active enrollment was required of program participants. The CYSHCN Program served 794 participants in FY2011.

SHCN also administered the Healthy Children and Youth (HCY) Program through a cooperative agreement with the Department of Social Services, MO HealthNet Division (MHD) (Medicaid). The HCY Program implements a portion of Early Periodic Screening, Diagnosis Treatment (EPSDT) requirements including assessing the need for in-home nursing services (such as personal care, nursing care and skilled-nursing visits). SHCN staff prior authorized medically necessary in-home nursing services and provided service coordination for participants. 2,386 participants were served through the HCY program in FY2011.

Through the Family Partnership Lunch 'n Learn families and professionals toured the Shriners Hospital in St. Louis and learned about programs to help families with the cost of care. Family Partnership coordinated a referral network with Shriners Hospital for families who need support and would like more information about options available for their children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. School Health Posts Information related to Medicaid on School Health Website.			X	X
2. CCHC program provided resource information and assistance to child care providers and/or parents on accessing a system of comprehensive care for a child with special health care needs.		X	X	
3. SHCN administered the Children and Youth with Special Health Care Needs Program and the Healthy Children and Youth Program.		X		X
4. SHCN Family Partnership Initiative (support network for family members).		X		X
5. SHCN utilized electronic database for statewide data collection consistent with federal data collection regarding adequacy of insurance and maintained data link with Department of Social Services to obtain participant Medicaid status.				X
6. SHCN provided service coordination for program participants including completing Service Coordination Assessments. Standard protocols were maintained to monitor referrals. Service Coordinators received training.		X		X
7. SHCN distributed the Insurance Comparison Checklist and the Insurance Fact Sheet and collaborated with other entities to promote adequate insurance.		X		X
8. SHCN collaborated with managed care organizations, Systems of Care Boards, DSS, DMH, and DESE to obtain		X		X

information about CYSHCN that transition within the systems of care.				
9. SHCN collaborates with the following grant initiatives: Family to Family Health Information Center, Autism Spectrum Disorder, and Pediatric Care Coordination Grant.		X		X
10. SHCN Service Coordinators complete Service Coordination Assessments with participants/families of the CYSHCN program and the HCY program, which includes assessing insurance availability for medical, vision, and dental services.		X		X

b. Current Activities
All activities listed in Table 4a will be continued.

School Health Program continues to coordinate seminars for school nurses on how to assist families to enroll in Medicaid.

SHCN is currently transitioning into an improved participant information web based system. Enhancements to the system include improvements in obtaining real time detailed Medicaid information for participants.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

SHCN will review materials related to adequacy of insurance and revise documents as needed. In addition the electronic claims entry system will progress forward in preparation for SHCN providers to begin using the electronic claims system.

CCHCs will provide resource information and assistance to child care providers and/or parents on accessing a system of comprehensive care for a child with special health care needs including referrals to MO HealthNet for Kids.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	83.2	90.5	90.7	90.9	91.1
Annual Indicator	90.1	90.1	65.5	65.5	65.5
Numerator					
Denominator					
Data Source		NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2012	2013	2014	2015	2016
Annual Performance Objective	65.7	65.7	65.9	65.9	65.9

Notes - 2011
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. The 2009-2010 percentage 65.5% in Missouri was close to the 55th percentile state level and slightly higher than the national figure of 65.1%.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010.

Notes - 2009
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS_CSHCN), conducted by HRSA and CDC, 2009-2010.

a. Last Year's Accomplishments
SHCN's Assistive Technology contract improved access and independence of children and youth with special health care needs. In FY2011 the assistive technology services and devices provided were coordinated with a total of 93 entities (families, medical homes, schools and service coordinators) for 33 children. The average federal poverty level of the families served was 160%; nine of these families had income below this level. The 33 families resided in various counties throughout the state. Projects included: ramps, vehicle modifications, augmentative communication devices, mobility devices, hearing devices and environmental enhancements. The cost for most of these projects averaged over $2,400. Substantial coordination with multiple funding sources occurred to finance projects. Missouri Assistive Technology was able to leverage funds from six additional organizations or agencies totaling $17,837 to supplement MCH funds. Communication with families, contractors, and Service Coordinators assured that the projects were completed satisfactorily and according to the Americans with Disabilities Act.

SHCN collaborated with external agencies to promote organized community-based service systems for children with special health care needs and participated in statewide promotional activities increasing knowledge, understanding and availability of SHCN programs and services. In FY2011 SHCN exhibited at 14 conferences reaching 3,510 Missourians.

Though the ICS Grant ended May 31 2011, activities related to this grant were sustained through the Family to Family Health Information Center grant. Through the Family to Family Health Information Center Grant, SHCN partnered with Missouri Family Voices and University of Missouri Kansas City (UMKC) to develop resources related to services for children and youth with special health care needs to be disseminated to families in a manner which is easy to use and accessible. Families and professionals attended quarterly stakeholder meetings to share resource information and discuss barriers in delivery of services for children and youth with special health care needs.

The grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities through the Thompson Center in University of Missouri Columbia and the Missouri Rapid Response group developed a brochure, "Your Next Patient Has Autism" to post inside physician's offices and to mail to physician's offices.

SHCN Family Partnership Parent and Caregiver annual retreat theme was "Find Your Treasure." The goal of this retreat was to assist families in assuring community-based service systems are organized and easy to use. There were 105 participants/families and professionals in attendance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CCHC program provided training and consultation to child care providers and parents on delivery of comprehensive consistent care to children with special health care needs.		X	X	X
2. Activities to assure culturally competent services for SHCN participants/ families including utilizing professional interpreters, translating materials and participating in events to increase knowledge of cultural diversity.		X		X
3. SHCN contracts for assistive technology.	X	X		X
4. SHCN Family Partnership Initiative (support network for family members) Family Partners were regionally based to provide alocal support system.		X		X
5. The HCY and CYSHCN programs provide service coordination, including assessments, service plans, transition plans and emergency preparedness. Service Coordinators are regionally based to effectively connect participants with community resources.		X		X
6. Special Health Services' (SHS) participation in outreach activities and collaboration with external agencies, including emergency preparedness activities to assure needs of participants are addressed. CYSHCN Program provider recruitment.		X		X
7. Special Health Services (SHS) collaboration with grant activities.		X		X
8. SHS facilitation of the Missouri Brain Injury Advisory Council and the Traumatic Brain Injury Grant.		X		X
9. SHS participation in various commissions and councils.		X		X
10. SHCN promotion of professional development for Department staff and staff of contracted agencies.		X		X

b. Current Activities
All activities listed in Table 4a will be continued.

The Family to Family Health Information Center grant is developing diagnosis specific packets.

The University of Missouri -- Kansas City (UMKC) in collaboration with the Special Health Care Needs received a grant award: Enhancing Pediatric Care Coordination for CYSHCN Through Parent-to-Parent Mentoring to enhance care coordination for urban families with children and youth with special health care needs through integration of a parent-to-parent model of peer support within pediatric care clinics. The grant period is September 1 2011 through August 30 2014.

Family Partnership offers Community Connections during Lunch 'n Learn sessions to inform families of available resources to assist with navigating through the system.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

In an effort to improve service delivery for participants and families SHCN will evaluate the availability of internal resources and materials and make adjustments as identified to assure up to date materials are easy to access.

CCHCs serve on local organizations that work to coordinate services for children with special health care needs.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7	54.4	54.4	54.5	54.6
Annual Indicator	54.4	54.4	40.3	40.3	40.3
Numerator					
Denominator					
Data Source		NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	42	42	43	43	44

Notes - 2011
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be comparable.

The 2009-2010 percentage 40.3% in Missouri was close to the 40th percentile state level and slightly higher than the national figure of 40.0%.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010.

Notes - 2009
Indicator data comes from the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted by HRSA and CDC, 2009-2010.

a. Last Year's Accomplishments
Special Health Services (SHS) attended the MPACT tools for Life transition summit focused on students who have disabilities. SHS distributed program information and obtained resources from the summit.

SHCN obtained approval from CMS to continue the Physical Disabilities Waiver. The name of the waiver has changed to the Medically Fragile Adult Waiver to better represent the participants served. Through the application process the needs of HCY participants were evaluated to assist in assuring adequate services will be available as youth transition to adulthood.

Families who participated in the SHCN Family Partnership Caregiver Retreat received information regarding youth transition in order to prepare them for the needs of their child as they transition to adulthood.

The University of Missouri Kansas City Institute for Human Development (UMKC-IHD) grant to establish a Family to Family Health Information Center included mentoring activities to support families to better navigate services and systems to make successful transitions. Through the UMKC-IHD Integrated Community Services (ICS) grant a statewide youth leadership council was utilized to guide the design, implementation and evaluation of project transition activities. Though the ICS Grant ended May 31 2011, activities related to this grant were sustained through the Family to Family Health Information Center grant.

The grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities through the Thompson Center in University of Missouri Columbia focused efforts on developing ways the grant could allow for partnering with existing state youth leadership programs to support the inclusion of youth with Autism Spectrum Disorder in leadership development opportunities.

A subgroup of the Rapid Response committee focused on addressing transition for youth with Autism Spectrum Disorder. The subcommittee members served in an advisory capacity and developed a Transition Overview Training Module. In addition the subgroup identified possible youth related activities for the Thompson Center and University Extension. The Thompson Center maintained the Transitioning to adulthood website which provides resources for youth with Autism Spectrum Disorder and their families. The resources cover areas that must be considered as a young person becomes an adult such as: health care transitions, education and training, employment, and community living. The website includes a video from a child's perspective of transitioning and a parent's perspective. The site also includes handouts and contact information for any questions families or participants may have.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The SHCN Healthy Children and Youth Program and Children and Youth with Special Health Care Needs Program provision of service coordination, including assessments, service plans and transition plans.		X		X
2. SHCN collaboration with adult programs and services and		X		X

Children's Hospitals. (These hospitals have a strong focus on transition issues for youth with special health care needs.)				
3. SHCN collaboration with grant activities including Family to Family Health Information Center, Integrated Community Services, and Improved Services for Children with Autism Spectrum Disorder.		X		X
4. SHCN Family Partnership Initiative (support network for family members).		X		X
5. SHCN statistical data collection consistent with federal data collection regarding participants who report receiving services necessary to make transitions to all aspect of adult life.		X		X
6. SHCN training for Department staff and staff of contracted agencies; SHCN identified participants with upcoming life stage transitions.		X		X
7.				
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4a will be continued.

Families who participated in the SHCN Family Partnership Caregiver annual retreat received information from MPACT regarding "The Journey to Adulthood: What Parents Need to Know (Sexuality)." In addition a break out session of the retreat focused on Individualized Educational Plan (IEP): "The Journey at School."

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

SHCN will enhance their relationship with Children's Hospitals in Missouri that focus on transition issues for youth with special health care needs.

The SHS statewide meeting will provide information for Service Coordinators to assist families in preparing for transitions. In addition, SHS will participate in webinars coordinated by the National Health Care Transition Center, and distribute information obtained.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	82.3	82.9	80.4	72.3	66
Annual Indicator	82.1	71.1	71.8	73.8	73.8
Numerator	64487	57842	58791	59737	58191
Denominator	78547	81353	81883	80944	78849

Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	74.5	75.3	76	76.8	77.5

Notes - 2011
Estimated Vaccination Coverage with 4:3:1:3:3 Among Children 19-35 Months of Age - US, National Immunization Survey. Data is unavilable for 2011.2010 data used as a proxy for 2011.Population of infants <1 year of age in 2009 used as denominator estimate of 19-35 month olds in 2011. We also updated 2008,2009 and 2010 data with series 4:3:1:3:3.
Population Source: DHSS Missouri Information for Community Assessment (MICA)-Population.

It is not recommended for comparison to years prior to 2009 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples. 2008 and previous years remember though that the estimates are not directly comparable since they do not consider the brand type where some children may be counted as up to date with 3 doses but may require 4 doses to be up to date.

Notes - 2010
CDC no longer reports immunization rate for series 4:3:1:3:3. 2010 data based on 4:3:1:3:3:1 Series, US, National Immunization Survey, Q3/2009-Q2/2010. Population of infants <1 year of age in 2008 used as denominator estimate of 19-35 month olds in 2010.
Population Source: DHSS Missouri Information for Community Assessment (MICA)-Population.

We also updated 2008 and 2009 data with new series 4:3:1:3:3:1. Both MO and the nation have seen a decrease in the rate of childhood vaccination coverage for three consecutive years 2008-2010. Prior to 2008, MO's rates were generally comparable with the national rates; MO's rates have tended to be lower than the national rates since 2008.

The MO DHSS Immunization Program has been adding more health care providers to the Vaccines for Children program. However, many private health care providers have declined carrying vaccines in their practice due to cost and they refer these patients to local public health agencies, community health centers, etc.

An annual increase of 0.5% was set up for objectives 2011-2015, based on discussions with the MO DHSS Immunization Program.

Notes - 2009

Data is for the 4:3:1:3:3 Series, US, National Immunization Survey, Q3/2008-Q2/2009. Population of infants <1 year of age in 2007 used as denominator estimate of 19-35 month olds in 2009. Population Source: DHSS Missouri Information for Community Assessment (MICA)-Population.

Both MO and the nation have seen a decrease in the rate of childhood vaccination coverage for two consecutive years 2008-2009. Prior to 2008, MO's rates were generally comparable with the national rates; MO's rates had tended to be lower than the national rates since 2008 though the difference was not statistically significant.

The MO DHSS Immunization Program has been adding more health care providers to the Vaccines for Children program. However, many private health care providers have declined carrying vaccines in their practice due to cost and they refer these patients to local public health agencies, community health centers, etc.

The Hib vaccine supply has been re-established and health care providers are able to re-call children to receive their full immunization. However, it is harder to accomplish the re-call for immunization than taking advantage of an already scheduled visit during which time the vaccine would have been provided.

An annual increase of 0.5% was set up for objectives 2010-2014, based on discussions with the MO DHSS Immunization Program.

a. Last Year's Accomplishments
During 2011, Missouri's immunization program enhanced the state's immunization registry, ShowMeVax; implemented a quality improvement initiative for all Vaccines for Children providers and educated child care providers on state's immunization requirements.

ShowMeVax received several major enhancements during 2011 such as adding NDC numbers to the inventory management module and the development and release of a read-only version for school and child care providers. Since 2010 over 1.5 million immunizations have been entered into ShowMeVax with over 175,000 in September 2011 alone. ShowMeVax began receiving and sending HL7 messages.

Missouri implemented a required Quality Improvement Initiative for Vaccine for Children providers. Each provider is given a self-assessment listing 30 evidence-based processes that can improve efficiencies in administering vaccines and increasing rates. More than 750 improvement processes were fully implemented this year. As a result of this effort and others, local public health agencies participating in the Vaccines for Children program increased the immunization rate on the 4:3:1:3:3:1:4 series to 63 percent, up from 50 percent the previous year.

The Bureau of Immunization Assessment and Assurance partnered with the Section for Child Care Regulation and Center for Local Public Health Services to improve immunization rates of children attending Missouri child care facilities. More than 3,100 child care providers, staff and parents received a standardized training on the importance of immunizations and how to review and interpret immunization records.

LPHAs through MCH Coordinated Services increased collaboration with Section for Child Care Regulation, Bureau of Immunizations, and Child Care Health Consultation.

In FFY11 the CCHC program provided 280 hours of on-site consultation to 375 child care providers, had 807 phone consultations and conducted 186 hours of adult group training to 1,122 child care providers and 175 parents on keeping immunization records current and the completion of mandatory immunization reporting for child care providers. Additionally 15 health promotions (directed to children) were conducted within child care settings.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LPHAs through MCH Services program promoted and provided recommended immunizations to this age group through routine, off site and extended hour clinics, WIC, and other community outreach.		X	X	X
2. CCHC program provided training and consultation to child care providers, parents of children enrolled in child care and children regarding the importance of immunizations for children enrolled in child care settings.		X	X	
3. TEL-LINK, the toll-free information and referral line for MCH services provided referrals to callers for immunizations , took orders for immunization literature and listed immunizations as a potential referral in all TEL-LINK advertising.			X	
4. Text4baby, MO customized messages provide women enrolled prenatally through age one of their index child education on importance of immunizations and schedule. They are provided with a toll-free number to learn location of low cost immunizations.		X	X	
5. Through the MO Community Based and Nurse Family Partnership HV programs, prenatal women through age 2 of index child were educated on need for immunizations and provided schedule. Home visitors assist Mothers access immunizations and keep records.		X		
6. The Baby Your Baby Website and Baby Your Baby Keepsake Books promote recommended immunizations for infants and children. The Website will remain active through January 2013 .			X	
7. Through the ACA MIECHV funding, home visitors educate primary caregivers of importance of regular well child visits that include maintenance of up-to-date immunizations prenatally through age 5 of index child and assist in accessing immunizations.				X
8. MO Medicaid Managed Care Plans mailed reminder letters to members and made calls to parents whose children were not current on immunizations.		X		
9.				
10.				

b. Current Activities
All activities listed in Table 4a will be continued.

During 2012 MO's immunization program continues to enhance efforts to increase awareness on the importance of immunizations through key partnerships, outreach campaigns and materials distribution.

The state's immunization registry, ShowMeVax continues to show significant signs of rapid growth. As of July 2012 nearly 370 medical provider locations totaling over 2,500 individuals utilize ShowMeVax. Over 360 schools and child care facilities totaling 1,100 users have the ability to view and print immunization records. As of July 2012, 60 medical provider locations are regularly submitting HL7 immunization messages; nearly 120,000 immunizations will be processed through these messages in 2012. As of July 2012 over 28,400,000 immunizations administered to more than 2,900,000 individuals have been recorded in ShowMeVax through

direct data entry and electronic data exchanges.

The Bureau of Immunization Assessment and Assurance is partnering with Pfizer, Inc. to ensure MO's children are adequately immunized. Since November 2011 nearly 15,000 reminder cards have been released to parents of children 19 to 35 months old who are one immunization away from being fully protected against vaccine-preventable diseases.

The CCHC program has immunization compliance in child care and training of child care providers on the importance of immunizations as a priority health issue.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

During 2013 Missouri's immunization program is planning to build on current projects, campaigns and programs to further advance the benefit and usage of stakeholders and consumer groups.

CCHC program will continue to collaborate with the State's immunization and child care regulation programs to continue to develop/revise on an ongoing basis a coordinated plan with specific strategies to improve immunization rates, specifically among young children in child care. The CCHC program will continue to prioritize training, consultation and children's health promotions with child care providers, parents of young children in child care and children in child care, regarding immunization requirements and recommendations. This will include facilitating access to appropriate immunizations for children in child care, assisting with the timely reporting by child care facilities regarding enrolled children's immunization statuses and assisting child care providers to develop polices and to engage in evidence-based best practices around immunizations.

A Missouri-specific booklet on pregnancy and newborn health will be developed to replace the Baby Your Baby booklet. There will be specific information and recommendations on immunizations for infants and children.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	17.2	21.4	21	19.2	18.7
Annual Indicator	21.4	21.6	19.5	17.0	15.4
Numerator	2685	2662	2371	2047	1850
Denominator	125231	123266	121535	120445	120445
Data Source		MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of					

events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	15.1	14.8	14.5	14.2	13.9

Notes - 2011
Source: MO DHSS Vital Statistics-Birth data, U.S. Census Bureau, 2010 Population estimates. Numerator is provisional 2011 births to women age 15-17 years as of March 2012. Final data will be available in early 2013. Denominator is 2010 population number being used as proxy for 2011 Numerator and denominator for 2010 are updated with 2010 final birth number and 2010 population respectively.

The birth rate among girls 15-17 years of age in MO was 15.4 per 1,000 in 2011 (provisional), which decreased for three consecutive years 2009-2011.
A slight decrease of 0.3 per 1,000 is anticipated for 2012-2016, based on trend analysis and discussions with the Bureau of Health Promotion and Section for Healthy Families and Youth.

Notes - 2010
Source: Missouri Information for Community Assessment (MICA)-Births, DHSS Vital Statistics, MICA-Population. MO started using the 2003 revision of birth certificate in 2010. Numerator is provisional 2010 birth number to women age 15-17 years as of March 2011. Final data will be available early 2012. Denominator is 2009 population number being used as proxy for 2010. Final population data will be available in November 2011.

Numerator and denominator for 2009 are updated with 2009 final birth number and 2009 population estimate respectively.

The birth rate among girls 15-17 years of age in MO was 19.0 per 1,000 in 2010 (provisional), which decreased for two consecutive years 2009-2010.
2011-2015 objectives based on trend analysis and discussions with the Section for Healthy Families and Youth.

Notes - 2009
Source: Missouri Information for Community Assessment (MICA)-Births, DHSS Vital Statistics, MICA-Population. Numerator is provisional 2009 birth number to women age 15-17 years as of April 2010. Final data will be available November 2010. Denominator is 2008 population number being used as proxy for 2009. Final population data will be available November 2010.

Numerator and denominator for 2008 are updated with 2008 final birth number and 2008 population estimate respectively.

The birth rate among girls 15-17 years of age in MO was 19.2 per 1,000 in 2009 (provisional), which decreased by 11.1% compared with the rate in 2008 (21.6 per 1,000).

The Adolescent Health Program, MO DHSS is in the process of applying for several federal funded teen pregnancy prevention grants. Other organizations across the state are also planning for applying grants that support evidence-based teen pregnancy prevention initiatives and strategies to reach teens. Considering these efforts, MO expects to see a gradual decrease in teen birth rate in the next few years especially since the implementation of the potential programs in 2011.

a. Last Year's Accomplishments
DHSS became Wyman Teen Outreach Program (TOP) Replication Partner which will increase state capacity to provide training and technical assistance for local contractors implementing TOP. 327 youth participated in TOP; in subsequent years more youth will be served.

RFP issued to award PREP-funded contracts to reach youth in high need counties and youth in foster care. PREP will support replication of 3 evidence-based teen pregnancy prevention program models (TOP, Making Proud Choices, and Becoming a Responsible Teen).

Abstinence Education Grant Program (AEGP) was transferred to BHP in July 2011 which has fostered coordination of efforts with PREP. Contract with Lincoln University Cooperative Extension delivered the Choosing the Best (CTB) curriculum in areas serving high risk African-American youth; 420 youth completed programs. Bureau of HIV, STD and Hepatitis provides medically accurate information concerning STDs via special presentations at youth in CTB who are 14 years of age and older.

Talk with Me statewide media campaign encouraged communication between parents and adolescents. An investment of $175,000 yielded a value of $1.4 million in radio and TV spots.

DHSS Teen Pregnancy Prevention systems logic model was developed.

Input from school students informed development of new chapters on STDs and Healthy Relationships for An Ounce of Prevention preconception health education curriculum resource; 300+ educators were trained and evaluation developed.

Through MCH Services contracts some LPHAs address teen pregnancy prevention though mentoring programs and preconception health education with schools.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Teen Outreach Programs with Local Public Health Agencies (LPHAs) and community partners.		X	X	
2. Personal Responsibility Education Program (PREP) grant coordinated by Adolescent Health Program (AHP) supports replication and evaluation of evidence-based teen pregnancy prevention program models.		X	X	
3. Abstinence Education Grant Program (AEGP) supports abstinence education and youth development programs for adolescents; media campaign for parents/family members.		X	X	
4. Missouri Collaborative Teams are working with national, state, and community partners to address teen pregnancy, STD and HIV prevention and preconception health education for adolescents and young adults.		X	X	
5. DHSS works with public health and education agencies for Kansas, Iowa, and Nebraska and regional HIV/AIDS/STDs and Human Sexuality Education Conference.		X	X	
6. MCH Coordinated Systems staff offer consultation and technical assistance to school nurses, LPHAs and community collaboratives on evidence-based practices to address teen pregnancy.				X
7. LPHAs provide pregnancy testing, counseling and referral and some prenatal case management. Some LPHAs work in	X	X	X	X

collaboration with schools to provide education on teen sexual behaviors and reproductive health.				
8. The MCBHV and NFP home visiting programs educate women on the importance of birth spacing to prevent repeat teen pregnancies. This includes getting clients to their medical home to obtain family planning services or promoting abstinence.		X		
9. Through the First Time Motherhood grant's "It All Counts" Facebook page information was provided on planning for pregnancy to decrease the number of teen pregnancies.			X	
10. An Ounce of Prevention family and consumer sciences health and biology curriculum has been enhanced through the First Time Motherhood grant to include preconception health-related topics of healthy relationships and sexually transmitted infections.			X	

b. Current Activities
All activities listed in Table 4a will be continued.

PREP evaluation methods and online reporting tools developed by University of MO/Institute of Public Policy. Evaluations will include: process; fidelity of implementation; student outcomes; and community capacity. Training and technical assistance to all contractors are ongoing. Preliminary data are being collected.

Twenty new contracts awarded to support local evidence-based teen pregnancy prevention programs.

AEGP expanded to Hispanic youth population in southwest MO by direct contract with MO State University. An added benefit is Masters of Public Health and Social Work students are learning how to develop, implement and evaluate a public health program. Statewide media campaign continues with increased dissemination to Hispanic audiences.

LPHAs selecting prevent/reduce adverse birth outcomes are focusing on teen pregnancy prevention using a work plan based on the six levels of the Spectrum of Prevention model, identifying risk /protective factors to affect change in their communities from individual behavior through policy implementation.

The MCH home visiting programs funding through the MCH Block Grant and ACA MIECHV Grant educate women on the importance of birth spacing to prevent repeat teen pregnancies.

The "It All Counts" Facebook page continues to provide preconception health messages on importance of planning for pregnancy. LPHAs conduct health fairs/presentations at schools to increase the number of "fans".

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

LPHAs currently addressing this issue will progress into the second year of their three year work plans building on the assessment findings related to policies/practices and risk/protective factors related to teen pregnancy prevention.

GHC will continue to educate teens enrolled in the home visiting programs on birth spacing and collect data on repeat pregnancies. The Planning for a Baby brochure will be made available to educate teens on planning for a pregnancy.

An Ounce of Prevention preconception health curriculum will be used to educate teens about the importance of developing healthy lifestyle choices prior to pregnancy.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	35	31.6	32.6	29.1	25.1
Annual Indicator	28.6	28.6	24.4	24.4	24.4
Numerator	19355	19252	16675	16603	16406
Denominator	67677	67314	68340	68047	67239
Data Source		Missouri Oral Health Survey	Missouri Oral Health Survey	Missouri Oral Health Survey	Missouri Oral Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	24.4	24.4	25.4	25.4	25.4

Notes - 2011
Source: Missouri Oral Health Survey conducted every five years. The most recent data from Missouri Oral Health Survey 2009-2010 is used as proxy for 2011. Denominator is 3rd grade fall enrollment figure for 2010-2011 school year, from the Missouri Department of Elementary & Secondary Education. Numerator is estimated based on the 2009-2010 percentage.

Notes - 2010
Source: Missouri Oral Health Survey 2009-2010. Denominator is 3rd grade Fall enrollment figure for 2009-2010 school year, from the Missouri Department of Elementary & Secondary Education. Numerator is estimated based on the 2009-2010 percentage.

The Office of Primary Care and Rural Health (OPCRH) does not have a dental sealant program. The OPCRH currently funds a fluoride varnish treatment program (Preventive Services Program) and has funded a fluoride mouth rinse program in previous years. The OPCRH promotes the benefits of dental sealants through its oral health education program.

The Oral Health Program anticipates gradual improvement in the percent of third grade children receiving protective sealants on at least one permanent molar tooth.

Notes - 2009
Source: Missouri Oral Health Survey 2009-2010. Denominator is 3rd grade Fall enrollment figure for 2008-2009 school year, from the Missouri Department of Elementary & Secondary Education. Numerator is estimated based on the 2009-2010 percentage.

The Missouri Oral Health Survey 2009-2010 encountered low rate of school participation due to the H1N1 flu severely impacting school attendance. A convenience sample of 15 schools participating in the Missouri Oral Health Program were added to the sampling frame. Therefore, the 2009-2010 data may not be generalizable to all third grade children in Missouri.

There has been a decrease in school based dental sealant programs in Missouri because of funding constraints. A slight increase of 0.1% per year based on 2005 data was chosen to create future objectives for 2010-2014, with consideration of both past performance and discussions with the DHSS Oral Health Program.

a. Last Year's Accomplishments
The Oral Health Program does not have a sealant program. However, over 64,600 children received fluoride varnish applications during the 2010-2011 school year through the Preventive Services Program. Seven portable dental units were placed throughout the state for loan to dentists and/or hygienists conducting community outreach through the Portable Dental Equipment Program. Almost 1,200 dental sealants were placed using this equipment.

In FFY11 the CCHC program provided 43 hours of consultation or group training to 288 child care providers and 5 parents of young children, and 294 children's health promotions on the importance of oral health in young children including the benefits of dental sealants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fluoride varnish is applied through the Oral Health Program's Preventive Services Program (PSP).	X	X		
2. The Oral Health Program will continue advocating for dental sealants through dissemination of information promoting the benefits of sealants and by providing portable dental equipment for community outreach.		X		
3. LPHAs collaborate with schools to provide services such as screenings, fluoride varnish applications and dental referrals. Some LPHAs offer dental clinics or dental vans that serve surrounding communities.	X	X	X	
4. CCHC program provided training/consultation to child care providers/ parents and children, regarding the importance of oral health in young children including the benefits of dental sealants.		X	X	
5. MO Medicaid Managed Care Plans Performance Improvement Plans (PIP).	X	X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4a will be continued.

The Oral Health Program continues to offer PSP which has served over 60,000 children so far this school year.

CCHC program offers training and consultation for child care providers/parents/children regarding the importance of oral health in young children.

MO Medicaid Managed Care Plans participated in a Dental Performance Improvement Plan (PIP) which included: sending reminder letters to parents; outreach to parents of children seen in the ER for dental services; providing prenatal dental services through WIC offices; partnering with Head Start and child care facilities; distributing toothbrushes, floss and toothpaste to schools; creating a dental web page; and developing and distributing a dental provider toolkit.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

The CCHC program serves preschool-aged children and the intent is to encourage health habits before children enter kindergarten to avoid future dental health issues. CCHCs will focus adult training and consultation and children's health promotions around obesity prevention as a priority health issue including oral health and appropriate oral health habits. Information on the Missouri dental sealant program will be distributed and appropriate referrals made.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	3.5	3.5	3.1	2.7	1.8
Annual Indicator	3.6	3.1	2.8	1.8	3.1
Numerator	42	36	33	21	37
Denominator	1169228	1170036	1182542	1177625	1177625
Data Source		MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2.9	2.9	2.7	2.7	2.5

Notes - 2011
Source: MO DHSS Vital Statistics-Deaths. 2010 and 2011 are provisional death data as of March 2012. Final 2011 death data will be available in early 2013. U.S. Census Bureau, 2010 final Population estimates used as a proxy for 2011 denominator.

A slight decrease of 0.2 per 100,000 every two years is anticipated for objectives 2012-2016, based on a combination of trend analysis on data 2007-2011, and discussions with the Office of Epidemiology, Bureau of Health Promotion and Section for Healthy Families and Youth, MO DHSS.

Notes - 2010
Source: Missouri Information for Community Assessment (MICA) - Death, Missouri Vital Statistics, MO DHSS. MO started using the 2003 revision of death certificate in 2010. 2010 provisional death data as of April 2011. 2010 final death data will be available in early 2012. 2009 population estimate is used as a proxy for 2010. The 2010 population estimate for specific age groups will be available in November 2011.

Numerator and denominator for 2009 are updated with 2009 final death number and 2009 population estimate.

The death rate due to MVC among children under 15 in MO further decreased from 2.7 in 2009 to 1.8 per 100,000 in 2010 (provisional). A gradual decrease of 0.1 per 100,000 for every two years was chosen to create objectives 2011-2015, based on a combination of trend analysis on data 1999-2010, and discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2009
Source: Missouri Information for Community Assessment (MICA) - Death, Missouri Vital Statistics, MO DHSS. 2009 provisional death data as of April 2010. 2009 final death data will be available in November 2010. 2008 population estimate is used as a proxy for 2009. The 2009 population estimate for specific age groups will be available in November 2010.

Numerator and denominator for 2008 are updated with 2008 final death number and 2008 population estimate.

The death rate due to MVC among children under 15 in MO further decreased from 3.1 in 2008 to 2.7 per 100,000 in 2009 (provisional), though the decrease was not statistically significant. A gradual decrease of 0.1 per 100,000 for every two years was chosen to create objectives 2010-2014, based on a combination of trend analysis on data 1999-2009, and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
During FY 2011 eight local Safe Kids coalitions in Missouri provided Child Passenger Safety Services raising public awareness on seat belt usage among children under age 15 by 1,095 events covering 52 counties including Kansas City and St Louis City. Safe Kids conducted 17 Child Passenger Safety technician training events, checked the car seats and helped in proper installations, distributed car seats, booster seats at health and safety fairs, Back to School fairs at hospitals, community centers, and public libraries reaching different communities. The coalitions work closely with law enforcement officers, fire fighters and paramedics, medical and health professionals, educators, parents, business, public policy makers and most importantly kids to reinforce child passenger safety.

In Macon County the LPHA assisted the majority of local child care providers in implementing child passenger safety policies. Lincoln County passed a local ordinance forbidding the resale of car seats. Partnerships with MO Safe Routes to School program, MoDOT and local communities resulted in funding for underserved communities to improve sidewalks, ADA upgrades, signage and crosswalk installations.

In FFY11 CCHC program provided 11 hours of consultation and group training to child care providers and 4 children's health promotions regarding motor vehicle safety in young children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Eight SAFE KIDS Coalitions covering 38 Missouri counties provided Child Passenger Safety primary prevention interventions to children aged 0-14 yrs.			X	X
2. Majority of LPHAs have child passenger safety programs in their communities. In collaboration with MoDOT, Safe Kids and community partners, car seats are provided to low income families at no charge.			X	X
3. LPHA contractors implement evidence-based interventions; collect/compile data from community partners; evaluate data and outcomes; report back to the community partners and local media; advocate for and support environmental and policy changes.		X	X	X
4. LPHAs and schools collaborate with MoDOT, MO Coalition for Roadway Safety, MO Assoc of School Nurses and CDC-Regional Network Program to reduce motor vehicle mortality rates through programs such as Arrive Alive and Battle of the Belts campaigns.			X	X
5. All LPHAs are represented on the local Child Fatality Review Boards.			X	
6. CCHC program provided training and consultation to child care providers and children on motor vehicle safety.		X	X	
7. Through the MCBHV, NFP and MIECHV programs, families were educated on car seat safety and were assisted in obtaining and installing a safe age-specific car seat for their child.		X		
8. Through the customized Text4baby program women receive educational messages on car seat safety and are provided with a toll-free number to assist them in obtaining a car seat or installing a car seat properly.			X	
9. A series of car seat safety cards are distributed through the DHSS warehouse and at regional exhibits to educate families on car seat safety during pregnancy and for infants, toddlers and adolescents.			X	
10.				

b. Current Activities

All activities listed in Table 4a will be continued.

The Missouri's Unintentional Injury Prevention Program addresses injury prevention as a health priority issue with community, regional and state partners such as Safe Kids, Local Public Health Agencies, Missouri's Children's Trust Fund, School Health Program, Adolescent Health Program, MO Department of Transportation, MO State Highway Patrol, U.S. Consumer Product Safety Commission and MO Injury and Violence Prevention Advisory Committee (MIVPAC) to reduce the mortality rate in children aged 0-14 yrs due to motor vehicle injuries.

A new Safe Kids North West Coalition has been started and providing services in Mercer, Grundy and Nodaway Counties from March 2012. Columbia Safe Kids Coalition extended its services to Callaway County. As of current FFY 12 Safe Kids have conducted 260 health events including 3 Child Passenger Safety trainings and has reached 28,349 targeted audiences.

Buckle Up, Tween Safety, Back Seat Boss and Safety In and Around the cars are the campaigns which educate parents and caregivers on seat belt usage and hazards cars can pose to children

like Hyperthermia/ Heat stroke and Trunk entrapment.

LPHAs are addressing distracted driving such a texting and cell phone usage to reduce the risk of crashes. Child passenger seat safety programs address the socioeconomic risk factors for early childhood deaths related to motor vehicle crashes by providing seats and boosters to those who cannot afford them.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

LPHAs will continue to address this issue by building on this year's progress as they work through activities within their community to meet system outcomes for each level of the spectrum of prevention.

The Injury and Violence Prevention Program (IVPP) will continue to partner with Missouri SAFE KIDS Coalitions. Coalitions will continue to provide car seats and specific interventions for child passenger safety as well as provide training to Child Passenger Safety Technicians and explore collaborations to extend the prevention services to other counties.

The IVPP will continue to work with Missouri Injury and Violence Prevention Advisory Committee (MIVPAC) to reduce mortality rate in children 0-19 yrs due to motor vehicle crashes through education, training and technical assistance. The MIVPAC will continue to explore other collaborations that may foster injury prevention efforts.

Injury and Violence Prevention program is working with MODOT on developing Missouri's Arrive Alive 2012-2016 Blue Print to Save More Lives. It contains strategies to reduce traffic crashes on Missouri roads, ultimately saving lives and reducing injuries.

The IVPP will continue to improve and update its website to serve as an injury resource and link to other resources for prevention activities .

A Missouri-specific booklet will be developed to include recommendations and laws related to car seat safety in Missouri from newborn until 5 years of age.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	34	34.9	35.1	38.4	38.6
Annual Indicator	30.5	33.0	38.2	35.1	35.1
Numerator	23957	26846	31279	28411	27675
Denominator	78547	81353	81883	80944	78849
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	35.3	35.7	35.9	36.1	36.3

Notes - 2011
Source: Breastfeeding percentage is from CDC's National Immunization Survey. 2010 data used as a proxy for 2011. 2011 (2009 birth cohort) final data will be updated in summer of 2013. The 2011 denominator is number of 2009 births in Missouri from DHSS Missouri Information for Community Assessment (MICA)-Births, MO Vital Statistics.

Objectives 2012-2016 were based on a combination of trend analysis of data 2003-2010 and discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2010
Source: Breastfeeding percentage is from CDC's National Immunization Survey. 2009 Final data is used as a proxy for 2010. 2010 (2008 birth cohort) final data will be updated in summer of 2012. The 2010 denominator is number of 2008 births in Missouri from DHSS Missouri Information for Community Assessment (MICA)-Births, MO Vital Statistics.

The percent of mothers who breastfed their infants at 6 months of age in Missouri increased from 31.8% in 2003 to 38.2% in 2009 (provisional). Objectives 2011-2015 were based on a combination of trend analysis of data 2003-2009 and discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2009
Breastfeeding percentage is from CDC's National Immunization Survey. 2009 Final data (2007 birth cohort). The 2009 denominator is number of 2007 births in Missouri from DHSS Missouri Information for Community Assessment (MICA)-Births, MO Vital Statistics. 2008 data (2006 birth cohort) is updated with final number.

The percent of mothers who breastfed their infants at 6 months of age in Missouri increased from 31.8% in 2003 to 38.2% in 2009. Objectives 2010-2014 were based on a combination of trend analysis of data 2003-2009 and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
Through MCH Coordinated Systems some LPHAs increased the number of breast pumps available in the community, presented worksite wellness programs on breastfeeding to local businesses and assisted with breastfeeding friendly policy development in their local community. In response to community interest Putnam County HD designed a breast feeding booklet and brought a national speaker to address the topic.

The WIC Program purchased single user electric breast pumps for WIC participants who are fully

breastfeeding and returning to work or school.

The WIC program developed an 18 Hour Basic Breastfeeding Course for WIC staff and healthcare professionals. This course is a requirement for agencies implementing the Breastfeeding WIC Clinic Criteria.

In FFY11 the CCHC program provided 37 hours of group training to 249 child care providers and 9 parents of children in child care regarding the benefits of breastfeeding and procedures/policies that support breastfeeding families.

Developed the Show-Me 5 Taking the First Steps to Being Baby-Friendly Initiative promoting five evidence-based maternity care practices supportive of breastfeeding to present to birthing hospitals. The initiative helps to increase breastfeeding initiation and continuation rates to meet the Healthy People 2020 breastfeeding goals by providing birthing hospitals with training and policy development to promote breastfeeding in their facilities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. LPHAs through MCH Coordinated Systems promote breastfeeding and provide resources for referrals to lactation experts through WIC, breast pump loan programs, billboards, prenatal case management and home visits to parents of newborns.		X	X	X
2. CCHC program provided group training to child care providers and parents of children in child care regarding the benefits of breastfeeding and how to support breastfeeding families in child care.		X	X	
3. TEL-LINK the toll-free information and referral line for MCH services provided referrals for breastfeeding , connected callers to state breastfeeding program managers and peer counselors as requested and took literature orders.			X	
4. DHSS Home Visiting Programs educate new mothers on the importance of breastfeeding and assist them in working with a lactation consultant if problems arise or to assist with initiation.		X		
5. Women who enroll in the Text4baby program receive customized messages educating them on the benefits of breastfeeding and providing information on support services available for breastfeeding mothers.			X	
6. The Baby Your Baby Website and Baby Your Baby Keepsake Books provide information about the importance of breastfeeding for infants and new moms.			X	
7. MO Breastfeeding Month was promoted in August 2011 with theme “Talk to Me, Support Me” targeted at educating dads and grandmothers about supporting moms’ breastfeeding. Various social media including transit ads and Facebook messages were used.			X	
8. Local WIC agencies provide Breastfeeding Peer Counseling Programs.		X		
9. WIC local and state staff implement the “Breastfeeding Community Partnership Special Funding Project.”		X	X	X
10. Glow and Grow trainings to all WIC local and state staff.		X		X

b. Current Activities
All activities listed in Table 4a will be continued.

Using life course theory and evidence-based practices, LPHAs through MCH Services contracts are working to reach infants at a critical early stage and change environments to increase their capacity to be healthy. Local efforts include assessing current practices in businesses, schools and child care; offering sample policies and TA on setting up lactation rooms and promoting to increase breastfeeding through prenatal case management. Livingston County is working with staff at Hedrick Hospital to consider becoming Breastfeeding-Friendly and leads a Breastfeeding Task Force. Linn County is offering educational programs about breastfeeding to church groups and local hospital auxiliary and developed a curriculum for expectant mothers and fathers.

Lactation Rooms are provided in State Office Buildings to promote breastfeeding among new mothers returning to work and assist these working moms in meeting their breastfeeding goals.

The Show-Me 5 Taking the First Steps to Being Baby-Friendly Initiative promoting five evidence-based maternity care practices supportive of breastfeeding is being created to present to birthing hospitals.

The WIC program implemented the "Breastfeeding Community Partnership Special Funding Project" with a goal to create/improve breastfeeding partnerships between local WIC agencies and healthcare professionals, employers and other community partners using evidence-based outreach methods.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

LPHAs will continue and expand on activities in the six levels of the spectrum of prevention work plans as described in Current Activities.

Educate interested hospitals in the Missouri Show Me 5 and implement the program in 10% of Missouri birthing hospitals.

A Missouri-specific booklet will be developed to include information about the importance of breastfeeding for infants and new moms and provide information on breastfeeding support for new mothers.

The WIC program will provide speakers addressing breastfeeding and nutrition during the Biannual Missouri WIC Conference in October 2012.

The WIC program will expand the Breastfeeding Peer Counselor (BFPC) program statewide by having 5 additional local WIC providers offer BFPC services. Currently 69 out of 112 have a BFPC program.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance	99	99	99	99	92.9

Objective					
Annual Indicator	97.2	96.8	92.9	93.3	96.2
Numerator	79580	78375	73230	71586	73867
Denominator	81883	80944	78849	76718	76785
Data Source		Missouri Newborn Hearing Screening Program	Missouri Newborn Hearing Screening Program	Missouri Newborn Hearing Screening Program	Missouri Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011
Source: Missouri Newborn Hearing Screening Program, DHSS Bureau of Genetics and Healthy Childhood. Numerator is provisional number of newborns screened before hospital discharge. Denominator is number of 2011 provisional recorded births as of April 2012 from DHSS Vital Statistics-Births. Final numbers for 2011 will be available in early 2013.

Numerator and denominator for 2010 are updated with final 2010 data.

Notes - 2010
Source: Missouri Newborn Hearing Screening Program, DHSS Bureau of Genetics and Healthy Childhood. Final 2010 data for number screened will be available January 2012. Numerator is provisional number of newborns screened before discharge. Denominator is number of 2010 provisional live births as of March 2011 from Birth data, DHSS Vital Statistics. Final birth number for 2010 will be available in early 2012.

Numerator and denominator for 2009 are updated with final 2009 data.

To be counted for "screened prior to discharge", the hospital must mark the box that states “screened prior to discharge.” It is possible that some programs skip that step when filling out the result form. It should be noted that 73,905 MO infants or 97.1% were screened prior to one month of age in 2010 (provisional) - the standard indicator that all state EHDI programs report to CDC.

Notes - 2009
Source: Missouri Newborn Hearing Screening Program, DHSS Bureau of Genetics and Healthy Childhood. Final 2009 data for number screened will be available January 2011. Numerator is provisional number of newborns screened before discharge. Denominator is number of 2009 provisional live births as of April 2010 from Birth data, DHSS Vital Statistics. Final birth number for 2009 will be available November 2010.

Numerator and denominator for 2008 are updated with final 2008 data.

The difference between 2008 and 2009 stems from the lack of a specific MOHSAIC report that counted those result forms marked “screened before discharge” in 2009. To be counted, the hospital must mark the box that states “screened prior to discharge.” It is possible that some programs skip that step when filling out the result form. It should be noted that 76,618 MO infants or 97.2% were screened prior to one month of age in 2009 - the standard indicator that all state EHDI programs report to CDC.

a. Last Year's Accomplishments

The MNHSP evaluated and continued to develop the MOHear Program. The MOHear Project is a collaboration between the Missouri Department of Health and Senior Services and Missouri State University. The MOHear Project purpose is twofold: 1) reduce the loss to follow-up rate of babies who fail to pass the newborn hearing screening and 2) provide unbiased support and education to families of children diagnosed with hearing loss as they enter the Part C system of services. A MOHear is a professional with expertise in the unique needs of infants with hearing loss.

Changes to the program included an increased focus on technical consultation with hospital screening programs.

The MNHSP developed a brochure titled "Your Child Needs Another Hearing Test." The brochure contains easy-to-read information about the importance of returning for a rescreening or audiological testing following failure to pass the initial newborn hearing screening. The MNHSP distributed the brochure to hospitals to give to parents of children who do not pass the initial hearing screening. The brochure has a "fax-back" page that allows the hospital to send the rescreening or testing appointment time to the MNHSP allowing the MNHSP to make a reminder phone call to the parents 24 hours prior to the appointment time.

The MNHSP continued to track and follow all infants who miss or fail the initial hearing screening.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Missouri customized Text4baby program provides education to women who enroll in the program or need to assure their newborn receives a newborn hearing screening prior to discharge from the hospital.			X	
2. Continue MOHear Program.	X	X		
3. Appointment Reminder Phone Calls.	X			
4. Tracking and follow-up of infants who miss or fail the newborn hearing screening.			X	
5. Hearing Screener lending program to five midwives/clinics that work with old-order Mennonite and Amish communities.		X		
6. Recruitment of extended team members for National Initiative for Children’s Healthcare Quality (NICHQ) Learning Collaborative and initiation of tests of changes aimed at improving hearing screening and intervention systems.			X	X
7. MOHear Project with hospitals with high rates of missed screenings and loss to follow up.	X	X		
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4a will be continued.

MOHear Program continues to provide technical expertise to hospitals with high loss to follow-up rates at the screening stage of the EHDI process.

The Missouri Newborn Hearing Screening Program (MNHSP) loaned hearing screening equipment to old-order Mennonite community health center and trained nurse to conduct screenings and report results to DHSS.

The MNHSP developed hospital hearing screening guidelines. Guidelines are available on DHSS website.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

The MOHear Program and Missouri Newborn Hearing Screening Program (MNHSP) Audiologist Consultant will continue to provide technical assistance and consultation to hospitals with a high rates of missed screenings and loss to follow-up. The MNSHP will continue to respond to Mennonite/Amish communities' requests for assistance with hearing screenings by collaboration with MOHear and equipment loans; work with managers of new home visiting programs to incorporate hearing screening education and gather information about cases of hearing loss; develop a "road map" or general plan of care for PCPs who care for a newborn with permanent hearing loss and ensure MoEVR is modified to include a free-text comments section.

Continue to educate pregnant women on newborn hearing screening through messages in Text4baby.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7.9	10.5	10.4	6.7	9.2
Annual Indicator	10.4	6.8	9.5	8.9	8.9
Numerator	150454	96051	136574	124482	124482
Denominator	1441898	1413974	1433930	1393977	1393977
Data Source		US Census Bureau. Current Population Survey	US Census Bureau. Current Population Survey	US Census Bureau. Current Population Survey	US Census Bureau. Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	8.7	8.6	8.5	8.4	8.3

Notes - 2011
Source: US Census Bureau. Current Population Survey (CPS), Annual Social & Economic Supplement (ASES), 2011. The 2011 survey reflects insurance coverage in 2010. This measure is for children <18 years of age.
Data from the CPS, ASES, 2012 will be updated in summer of 2013.

Annual indicator, numerator and denominator for 2010 are updated with 2010 insurance coverage data from the CPS, ASES, 2011.

The percent of children without health insurance in Missouri in 2010(8.9%) was significantly lower than the nation figure (9.8%). Objectives 2012-2016 were based on a combination of trend analysis on data 2007-2010, and discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2010
Source: US Census Bureau. Current Population Survey (CPS), Annual Social & Economic Supplement (ASES), 2010. The 2010 survey reflects insurance coverage in 2009. This measure is for children <18 years of age.

Data from the CPS, ASES, 2011 will be updated in summer of 2012.

Annual indicator, numerator and denominator for 2009 are updated with 2009 insurance coverage data from the CPS, ASES, 2010.

The percent of children without health insurance in Missouri in 2009(9.7%) was slightly lower than the nation figure (10%). Objectives 2011-2015 were based on considerations of potential impact of health care reform and discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2009
Source: US Census Bureau. Current Population Survey (CPS), Annual Social & Economic Supplement (ASES), 2009. The 2009 survey reflects insurance coverage in 2008. This measure is for children <18 years of age.
Data from the CPS, ASES, 2010 will be available at the end of September 2010.

Annual indicator, numerator and denominator for 2008 are updated with 2008 insurance coverage data from the CPS, ASES, 2009

The percent of children without health insurance in Missouri showed a gradual increasing trend from 2001 to 2007. However, the percentage decreased from 10.4% in 2007 to 6.8% in 2008. A slight decrease of 0.1% per year was set up for objectives 2010-2014, with considerations of potential policy changes and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments

To address increasing access to dental care for uninsured and underinsured Missouri children, the Oral Health Program's Preventive Services Program (PSP) expanded capacity and served over 64,600 children during the 2010-2011 school year. The program provides an annual oral screening conducted by a dentist or dental hygienist, oral hygiene education and items (toothbrush, toothpaste, and dental floss), 2 fluoride varnish applications per year and a referral network of community dentists to provide treatment for unmet dental needs.

The OPCRH continues to promote access to dental, behavioral and medical health care through increased FQHC access. The OPCRH continues to provide health professional loan and loan repayment programs that increase access to healthcare in underserved areas and for vulnerable populations. The OPCRH assists FQHCs with health care by collaborating with the Missouri Primary Care Association for recruitment of practitioners to provide primary health care in underserved areas.

The School Health Program requested school nurses to identify children without health insurance by including this request for information on annual health inventory form.

In FFY11 the CCHC program provided information to child care providers and parents of children in child care regarding MO HealthNet for Kids/Medicaid when conducting training/ consultation around health and safety.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OPCRH promotes access to primary health care through increased FQHC access, health professional loan/repayment programs, and by collaborating for recruitment of practitioners to provide care in underserved areas.			X	X
2. Oral Health Program's Preventive Services Program provides an annual oral screening, oral hygiene education, 2 fluoride varnish applications per year and a referral network of community dentists to provide treatment for unmet dental needs.	X	X		
3. LPHAs screen children for health insurance through programs such as WIC and immunizations and refer uninsured to MO HealthNet.	X	X		
4. Special Health Care Needs administered the Children and Youth with Special Health Care Needs Program and the Healthy Children and Youth Program, including service coordination.		X		X
5. SHCN Service Coordinators complete Service Coordination Assessments with participants/families of the Children and Youth with SHCN Program and Healthy Children and Youth Program to assess insurance availability for medical/vision/ dental services.		X		X
6. SHCN Family Partnership Initiative (support network for family members) is used to disseminate information about Medicaid and health insurance availability.		X		X
7. SHCN distributed the Insurance Comparison Checklist and the Insurance Fact Sheet and collaborated with other entities.		X		X
8. SHCN collaborated with managed care organizations. Systems of Care Boards, DSS, DMH and DESE to obtain information about children with special health care needs that transition within the systems of care.		X		X

9. Home visitors through the MCBHV and NFP programs assist families without health insurance on enrolling in MO HealthNet and enrolling their newborn after delivery.		X		
10. Child Care Health Consultation (CCHC) program, School Health Program, Baby Your Baby Website and Baby Your Baby Keepsake books, TEL-LINK and Text4Baby provide information for referrals to Missouri Medicaid resources.		X		

b. Current Activities
All activities listed in Table 4a will be continued.

The OPCRH continues offering health professional loan and loan repayment programs and assisting FQHCs with securing health professionals to provide increased access to primary health care in underserved areas and for vulnerable populations.

School Health Program continues to encourage schools to include information related to health insurance on health inventory form and are now including discussion about what to do when families say no health insurance. Information about Medicaid and FQHC's are featured.

TEL-LINK, the toll-free information and referral line for maternal and child health services, provided referrals to Missouri families for MO HealthNet. The Department of Social Services included the TEL-LINK name and toll-free number under childhood resources which allowed Missourians access to information . This was also a direct linkage to the TEL-LINK website for more information on the program.

Medicaid Managed Care Plans send text message reminders to members reminding them to renew their benefits.

School Health Services Program provides regional workshops for school nurses and school social workers on enrolling children in Medicaid. Annual updates related to Medicaid enrollment are sent by email to all school health services personnel. The program works with the MO HealthNet Division in DSS to assure schools have applications and outreach materials in multiple languages.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

The School Health Program will facilitate workshops, webinars and e-mail blasts with information related to enrolling eligible children in Medicaid.

A Missouri-specific booklet will be developed to include information about financial resources for pregnant women and children including MO HealthNet.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	30	30	30.7	30.6	29.6

Annual Indicator	30.3	30.7	30.3	29.8	28.9
Numerator	16665	18699	18226	20129	19610
Denominator	55001	60908	60150	67547	67853
Data Source		Pediatric Nutritional Surveillance System	Pediatric Nutritional Surveillance System	Pediatric Nutritional Surveillance System	Pediatric Nutritional Surveillance System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	28.9	28.6	28.4	28.2	28

Notes - 2011
Source:CDC data tables from 2011 Pediatric Nutritional Surveillance System.

Notes - 2010
Source:CDC data tables from 2010 Pediatric Nutritional Surveillance System.

WIC anticipates further decrease in percent of overweight/obesity among WIC children in the next five years.

Notes - 2009
Source:CDC data tables from 2008 Pediatric Nutritional Surveillance System. 2008 numbers being used as a proxy for 2009. The 2009 numbers will not be available until Fall 2010.

WIC has implemented the new WIC food package since October 2009. We anticipate a gradual decrease in the overweight rate among WIC children.

a. Last Year's Accomplishments
Ste. Genevieve and St. Francois Counties have done fruit and veggie tastings with WIC kids in accordance with National Nutrition Month with positive response to such "new" foods as prunes, red cabbage, and radishes.

Benton County worked with community partners to apply and receive funding for a walk in refrigerator for the local food bank so they could accept and distribute more fresh produce.

Missouri was one of 14 states selected to receive a Child Care Wellness Grant from USDA. The goals of the grant activities are to improve the nutrition and physical activity environments in child care centers by increasing the number of providers meeting specific nutrition recommendations laid out in the Missouri Eat Smart Guidelines for Child Care and implementing "I Am Moving, I Am Learning." The Child and Adult Care Food Program (CACFP) is overseeing implementation of

grant activities. Twelve child care facilities have been recognized as "Eat Smart" centers to date and hundreds of providers have been trained on how to implement the Eat Smart Guidelines.

The Team Nutrition Program has been supporting the Eat Smart initiative by providing in-depth technical assistance to a limited number of centers as well as providing "Cooking Matters" training to providers which focuses on preparing healthy meals with chefs.

Missouri kicked off the Children in Nature Challenge encouraging communities and families to get outside and explore nature. At least 3 communities were recognized as Children in Nature Communities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Local Public Health Agencies (LPHAs) addressed obesity prevention through improved nutrition and physical activity interventions with WIC eligible families and other programs serving young children.		X	X	
2. LPHAs work to increase healthier eating and physical activity with children and their parents.		X	X	
3. Some LPHAs provide vouchers/coupons to WIC clients for fresh produce from Farmer's Markets and local Wal-Mart.			X	
4. The CCHC program provides information to child care providers and parents of children in child care regarding WIC.		X	X	
5. TEL-LINK provided information and referrals on WIC to individuals who called the toll-free maternal and child health line.			X	
6. Local WIC providers participate in Fit WIC Missouri.		X		
7. Continue Children in Nature Challenge.			X	
8. Kansas City collaborative participates in "Collaborate for Healthy Weight."		X	X	
9.				
10.				

b. Current Activities
All activities listed in Table 4a will be continued.

The MO WIC Approved Food list was revised by replacing cheese in the child food package with skim to 2% milk.

LPHAs are addressing obesity prevention through MCH Services contracts; implementing Fit WIC with WIC families; surveying WIC clients on amount of physical activity; developing social media/blog/webpage to market to WIC clients and community; LPHAs working with city and child care providers to have children plant/work in community gardens; evaluating caloric/fat content of foods offered at school sporting events.

MO continues to implement Eat Smart Guidelines. CACFP made mini-grants available to centers to assist in meeting guidelines and provide training and technical assistance. MO continues to implement "I Am Moving, I Am Learning" and "Cooking Matters" for child care centers.

A team of Kansas City agencies were chosen to participate in "Collaborate for Healthy Weight," a nation-wide initiative led by the National Initiative for Children's Healthcare Quality and supported by HRSA. Partners include Children's Mercy Hospitals and Clinics, Weighing In (with support from the Healthcare Foundation of Greater Kansas City), Family Health Partners, YMCA of

Greater Kansas City, KC Healthy Kids and the KC MO Health Dept. This effort began in KC, MO and expanded to Jackson, Platte, Clay and Cass Counties. The collaborative uses 54321 Fit-Tastic! messages and assists individuals to set and stay the course for a healthy weight

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

WIC will provide guidance to WIC local agencies in MO to implement Fit WIC MO strategies in 100% of clinics in FY14. The State WIC office will begin providing MyPlate nutrition education to the local WIC agencies for education to WIC participants.

LPHAs will build on assessment findings from the current year, to develop and implement strategies to work toward system outcomes identified in their three year work plan.

The CACFP and Team Nutrition Program continue to implement the Eat Smart initiative and "I Am Moving, I Am Learning". The Department plans to develop a set of physical activity guidelines for child care facilities akin to the Eat Smart Guidelines. Also, the Bureau of Health Promotion (BHP) will fund one county to work on improving their breastfeeding initiation and duration rates.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	19	19.6	18	20.5	18.7
Annual Indicator	18.4	21.8	18.9	16.7	16.7
Numerator	15066	16538	13985	11879	11879
Denominator	81883	76034	73863	70959	70959
Data Source		Missouri PRAMS	Missouri PRAMS	Missouri PRAMS	Missouri PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	16.5	16.5	16.3	16.3	16.1

Notes - 2011
The 2011 estimated percentage of maternal smoking during the last 3 months of pregnancy is not available yet. The 2010 data based on the 2010 Missouri PRAMS survey response is used as proxy for 2011. 2011 PRAMS data will be available January 2013. Numerator and Denominator based on weighted PRAMS data.

A gradual decrease in maternal smoking rate during the last 3 months of pregnancy was set up

for objectives 2012-2016, based on discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2010
The 2010 estimated percentage of maternal smoking during the last 3 months of pregnancy is not available yet. The 2009 data based on the 2009 Missouri PRAMS survey response is used as proxy for 2010. 2010 PRAMS data will be available January 2012. Numerator and Denominator based on weighted PRAMS data.

A gradual decrease in maternal smoking rate during the last 3 months of pregnancy was set up for objectives 2011-2015, based on discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2009
Source: The 2009 estimated percentage of maternal smoking during the last 3 months of pregnancy from 2009 PRAMS survey. Numerator and Denominator based on weighted PRAMS data.

a. Last Year's Accomplishments
The Missouri Tobacco Quitline (Quitline) provided coaching services to 91 pregnant women from October 2010 to September 2011 .

LPHAs addressing smoking cessation during FFY07-11 evaluated their efforts and report seeing community changes in attitude on the negative effects of tobacco and increased community awareness of the dangers of smoking, smokeless tobacco and second hand smoke. Pregnant women who smoke and were interested in a smoking cessation class increased as well as the number of individuals reported to never have smoked.

The CCHC program provided 29 hours of group training to 232 child care providers and 12 children's health promotions on the dangers of second-hand smoke and environmental triggers for asthma in the child care setting.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LPHAs screen and counsel clients for tobacco use through pregnancy testing, WIC, prenatal case management and refer or offer smoking cessation programs.		X	X	
2. LPHAs working with community partners are expanding smoke free policies in businesses, schools, and cities.			X	
3. CCHC program provided group training to child care providers and children's health promotion programs on the dangers of second-hand smoke and environmental triggers for asthma in the child care setting.		X		
4. Women enrolled in MCBHV and NFP HV programs are assessed for smoking and educated on importance of not smoking during pregnancy. Women who screen positive are provided information on Quit Line and assisted with smoking cessation using the 5 A's.		X		
5. Customized Text4baby messages are provided to women who enroll in the program on the dangers of smoking during pregnancy and smoking cessation resources including the Quit Line.			X	

6. The Baby Your Baby Website, Baby Your Baby Keepsake Books and educational brochures/cards distributed through the DHSS warehouse provide information about smoking cessation during pregnancy and the dangers of tobacco use and secondhand smoke.		X		
7. The MO Tobacco Quitline offers smoking cessation for pregnant women who smoke. Women who are breastfeeding and who plan to become pregnant in the next three months can also participate.	X	X		
8. MO Medicaid Managed Care Plans provide members with information on the Quitline and other tobacco cessation programs.	X	X	X	
9.				
10.				

b. Current Activities
All activities listed in Table 4a will be continued.

In October 2011, Quitline began offering enhanced coaching services to pregnant women including up to ten calls during pregnancy and postpartum. The calls include several intervention calls in the two-week period following a quit attempt, one just before the due date, and two calls within two months after the baby's delivery help the participant to develop skills to remain quit and reduce health risks to the baby from exposure to secondhand smoke.

Enhanced Quitline services provide for women who are breastfeeding and women who are planning to become pregnant in the next three months to participate in up to five proactive coaching calls.

From October 2011 to March 2012 the Quitline served 60 pregnant women, a small increase over 51 served in the same time period the previous year.

LPHAs addressing the priority health issues of preventing adverse birth outcomes or tobacco prevention include prenatal smoking interventions, preconception health education and environmental and policy changes within their communities.

Women enrolled in the MCH block and ACA MIECHV funded home visiting programs are assessed for smoking on enrollment and at intervals throughout their pregnancy and postpartum and are educated on the importance of not smoking during pregnancy.

Customized Text4baby messages continue to be provided to women in the program on dangers of smoking during pregnancy and smoking cessation resources including Quitline.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

Current activities and strategies of LPHAs will continue and expand.

Many women working in child care facilities are of reproductive age. The CCHC program will continue to offer training to child care providers and parents of children in child care on the hazards of smoking, secondhand smoke and environmental triggers for asthma as it pertains to smoking. Information on smoking cessation programs will also be offered.

Continue to educate women enrolled in the home visiting programs and the Text4baby program on the dangers of smoking during pregnancy and refer them to the Quit-Line.

A Missouri-specific booklet will be developed to include information about the dangers of tobacco use and secondhand smoke during pregnancy.

GHC and OPI are currently in the process of and will complete in 2013 revision of all educational brochures related to healthy pregnancies and infants. The brochures will be Missouri-specific and include information on the dangers of smoking during pregnancy and resources for smoking cessation including the Quit-Line.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	5.3	8	9.5	8	7.8
Annual Indicator	8.5	11.6	7.9	7.8	8.5
Numerator	35	48	33	33	36
Denominator	414182	412660	418341	423786	423786
Data Source		MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	7.8	7.7	7.6	7.5	7.4

Notes - 2011
Source: MO DHSS Vital Statistics-Deaths. Numerator is provisional 2011 death number of persons age 15 through 19 years as of March 2012. Final number will be available in early 2013. The 2010 population estimate of persons age 15-19 years is used as a proxy for 2011.

Objectives for 2012-2016 were based on trend analysis of data 2007-2011 and discussions with the Bureau of Health Promotion and Section for Healthy Families and Youth, MO DHSS.

Notes - 2010
Source: DHSS Vital Statistics. Numerator is provisional 2010 death number of persons age 15 through 19 years as of March 2011. Final number will be available in early 2012. The 2009 population estimate of persons age 15-19 years is used as proxy for 2010. The 2010 population number will be available November 2011.

MO started using the 2003 revision of death certificate in 2010. Objectives for 2011-2015 were based on trend analysis of data 1999-2010 and discussions with the Section For Healthy Families and Youth, MO DHSS.

Notes - 2009
Source: DHSS Vital Statistics. Numerator is provisional 2009 death number of persons age 15 through 19 years as of April 2010. Final number will be available November 2010. The 2008 population estimate of persons age 15-19 years is used as proxy for 2009. The 2009 population number will be available November 2010.

The increase in MO's teen suicide rate observed in 2008 did not continue in 2009. The teen suicide rate decreased from 11.6 per 100,000 in 2008 to 8 per 100,000 in 2009 (provisional). Objectives for 2010-2014 were based on trend analysis of data 1999-2009 and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
Publicized the National Suicide Prevention Lifeline hotline number and increased the awareness of risk and protective factors of youth suicide to all Missouri school nurses through School Nurse Update and Missouri Association of School Nurse newsletters.

The School Health Program partnered with the Missouri Elementary School Principals' Association and the Center for Education Safety to offer Olweus Bullying Prevention Program to rural school districts. Awareness opportunities for school nurses and school staff related to LGBT students facilitated by the school health program.

Show Me Bright Futures project addressed social and emotional health for children and youth through the development of local community systems. CLPHS MCH staff continued to support the project offering consultation and technical support to three pilot projects in Moberly, Rolla, and Joplin.

MCH Services Program Manager participated in the Children's Safety Network Community of Practice and Missouri Injury and Violence Prevention Advisory Committee. The Injury and Violence Prevention Children's Safety Network (CSN) Project in Missouri selected rural suicide prevention in 15-19 year olds to address.

MCH program also sponsored a bullying prevention preconference workshop by Dr. Glenn Berry, national trainer for the Olweus Bullying Program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Injury and Violence Prevention Program, School Health and Adolescent Programs and the MO Dept of Mental Health, in collaboration with CSN's Community of Practice and MIVPAC raise the awareness to reduce youth suicide in Missouri.			X	X
2. Olweus Bullying Prevention Program in 16 rural school districts.			X	X
3. Suicide Awareness seminars sponsored at School Health Conferences.			X	X
4. Safe Space Kits offered to school nurses and school counselors.			X	X
5. MCH District Nurse continues provides ongoing technical assistance to school district implementing Olweus Bullying		X	X	

Prevention program.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4a will be continued.

The Injury and Violence Prevention Program is participating in Children's Safety Network, Youth Suicide Community of Practice. It helps provide education and resources to promote strategies and interventions to reduce the incidence of youth suicide in Missouri.

DHSS partners with the Center for School Safety, Children's Trust Fund and MO Elementary School Principals Association to promote the Olweus Bullying Prevention Program throughout MO. 16 MO rural schools have implemented the program with fidelity. This group met to share successes and challenges in implementing bullying prevention and identified a need for information related to LGBTQ. As a result, the Department of Mental Health will offer the "Trevor Project" for these schools.

The team is working on developing a Suicide tool kit which consists of Missouri data comparing to nation, best practices, interventions and free resources available in Missouri to reduce the incidence of Youth Suicide.

Bullying prevention curriculum in Polk was provided to 14 school counselors and suicide prevention information delivered to 52 area providers. Pettis County surveyed 4-6 grade students on bullying. Bright Futures in Mental Health pilot projects with DMH continue with plans for expansion statewide.

The Federal Partners in Bullying Prevention hosted a webinar on May 21, 2012, that explored the new and improved StopBullying.gov website.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

LPHAs plan coalition work with parent organizations and local leaders to advocate for bullying prevention efforts at local schools and educate youth, parents and providers on risk and protective factors.

The School Health Program will sponsor professional development seminars for school health staff related to suicide prevention, bullying prevention and addressing the unique needs of LGBQT students.

The 7th Annual "Show Me You Care About Suicide Prevention Conference" will be held during Fall 2012.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	80.9	77	78.5	79.2	78.1
Annual Indicator	76.2	81.1	78.7	76.6	78.9
Numerator	893	886	909	850	770
Denominator	1172	1092	1155	1110	976
Data Source		MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	79.1	79.1	80.1	80.1	80.3

Notes - 2011
Source: MO DHSS Vital Statistics-Births. Denominator is very low birth weight (VLBW) infants born to Missouri residents and delivered in Missouri, provisional data as of March 2012. Numerator is VLBW infants delivered at Level III Missouri hospitals. Final 2011 numbers will be available in early 2013. Very low birth weight (VLBW) defined as less than 1500 grams birth weight.

Numerator and denominator for 2010 are updated with 2010 final data.

Notes - 2010
Source: DHSS Vital Statistics. MO started using the 2003 revision of birth certificate in 2010. Denominator is very low birth weight (VLBW) infants born to Missouri residents and delivered in Missouri, provisional data as of March 2011. Numerator is VLBW infants delivered at Level III Missouri hospitals. Final 2010 numbers will be available early 2012. Very low birth weight (VLBW) defined as less than 1500 grams birth weight.

Numerator and denominator for 2009 are updated with 2009 final data.

There are multiple factors at play in this indicator such as competitive admission practices among hospitals and inappropriate admission based on insurance status. A modest improvement of 0.2% in this measure is set up for objectives 2011-2015, based on discussions with the Bureau of Health Informatics and the Section for Healthy Families and Youth, MO DHSS.

Notes - 2009
Source: DHSS Vital Statistics. Denominator is very low birth weight (VLBW) infants born to Missouri residents and delivered in Missouri, provisional data as of May 2010. Numerator is VLBW infants delivered at Level III Missouri hospitals. Final 2009 numbers will be available November 2010. Very low birth weight (VLBW) defined as less than 1500 grams birth weight.

Numerator and denominator for 2008 are updated with 2008 final data.

There are multiple factors at play in this indicator such as competitive admission practices among

hospitals and inappropriate admission based on insurance status. A modest improvement of 0.5% in this measure is set up for objectives 2010-2014, based on discussions with the Bureau of Health Informatics and the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments

Missouri hospitals are surveyed annually regarding the maternal and newborn services they provide and the experience, training, and certifications of their medical staff. Level of Care designations are made regularly by DHSS for statistical purposes using the survey results, supported by birth, infant death, fetal death and hospital discharge data. The criteria for distinguishing between the levels of care are based on guidelines from a 1986 survey of perinatal care by the National Institute of Child Health and Human Development, the 1994 DHSS "Show Me Buyer's Guide: Obstetrical Technical Report", and the 2004 'Levels of Neonatal Care' Policy Statement by the American Academy of Pediatrics.

Level I hospitals provide services for uncomplicated maternity and newborn cases as evidenced by having a well-newborn nursery. They have the ability to stabilize unexpected problems, provide neonatal resuscitation, and have mechanisms in place to initiate maternal and neonatal transports when needed. Level II hospitals have Level I functionality, plus provide services for selected problems such as pre-eclampsia and premature labor at 32 weeks and later. Level II hospitals must have a chief of obstetrical services that is board-certified, or at least two active/associate obstetrical staff that are board-certified. A lab technician is available in-house 24-hours a day and anesthetist services are available 24-hours a day in a Level II hospital. As a general rule they deliver more than 500 infants per year and have organized programs to initiate and accept maternal-fetal and neonatal transports. Level III facilities have the functionality of Level II hospitals. They have the capacity to treat most serious maternal illnesses and abnormalities. Level III hospitals must be able to care for medically-fragile neonates in a Neonatal Intensive Care Unit (NICU) separate from their well-newborn nursery. Level III hospitals have an organized program to accept and direct transport of high-risk mothers and neonates.

The process of administering the hospital survey is such that designations for the current year's birth data are made using the prior year's hospital survey results. In other words, for this application, Level of Care designations for 2010 births were made using 2009 survey results. In 2010 the hospital survey was modified by OOE and BHI for the purpose of obtaining better information for making the Level of Care designations. Additional modifications were made to the 2011 hospital survey.

For 2009 births, the designations remained virtually the same from 2008, with only one hospital in Rolla being upgraded from Level I to II and one hospital in Joplin downgraded from Level II to I. With the 2009 designations, some women in northern and south central Missouri still had to travel up to 120 miles to reach the nearest Level III hospital.

Very Low Birth Weight (VLBW, less than 1500 g) is the denominator for this indicator because of its close relationship to premature births and infant mortality. VLBW infants are closely associated with very preterm births. In 2010, 47% of infant deaths in Missouri were VLBW. The American Academy of Pediatrics reported in 2004 that most studies that link neonatal outcomes with levels of perinatal care indicate that morbidity and mortality for VLBW infants are improved when delivery occurs in a Level III facility rather than a Level I or Level II facility.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Information for parents of premature infants is available on the DHSS website. These materials can be printed from the web by the parents or used by healthcare providers to educate parents	X	X		

on prematurity.				
2. TEL-LINK connected callers to LPHAs, prenatal clinics, pediatric and delivering hospitals.			X	X
3. BHI provided data needed to produce this measure. Birth weight and place of birth are collected through the vital statistics system. Level of care data are collected through the Annual Hospital Licensing Survey of Missouri Hospitals.				X
4. MO Medicaid Managed Care Plans collaborate with hospitals, parents and providers to assure members deliver at the most appropriate setting.		X	X	
5. Development and Implementation of Medicaid's "Summary of Key Change Concepts for NICHQ Neonatal Improvement Project" which is population based.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4a will be continued.

BVS and BHCADD will continue to provide the data needed to produce this measure. Level of care determinations also take into account volume of high-risk deliveries, transferred obstetric patients, and usage of advanced obstetrical procedures by facility from birth record data. Results of the modified hospital surveys will be used for the first time to make the Level of Care designations.

MO Managed Care Plans collaborate with hospitals, parents and providers to assure high-risk deliveries and neonates are cared for at the most appropriate facilities.

In response to MO RSMo 191.710 MO's Medicaid program is examining and improving hospital discharge and follow up procedures for premature infants born earlier than 37 weeks gestation to ensure standardized and coordinated processes are followed. The Medicaid program has developed a Summary of Key Change Concepts for NICHQ Neonatal Improvement Project which includes: identification and treatment of pregnant women at risk for high risk deliveries; identification of mothers at high-risk for prematurity and assuring their prenatal transfer to a tertiary NICU; assuring optimal resuscitation and stabilization of premature infants before transfer to appropriate facility. Included in these activities is establishing a maternal transport system which promotes early in utero transfer of women with threatened extremely premature delivery.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

BVS and BHCADD will continue to provide the data needed to produce this measure.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**

Annual Performance Objective	87.3	84.6	84	84.4	76.4
Annual Indicator	84.1	83.8	84.5	76.6	75.6
Numerator	68863	67844	66665	55783	52489
Denominator	81883	80944	78849	72860	69412
Data Source		MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75.8	76	76.2	76.4	76.6

Notes - 2011
Source: MO DHSS Vital Statistics-Births. Provisional 2011 data as of March 2012. Final 2011 data will be available in early 2013.

To be consistent with the definition used by MICA, starting from 2010 data, the denominator has been changed from including total live births to only including live births with known prenatal care status.

An annual increase of 0.2% is anticipated for objectives 2012-2016, based on trend analysis and discussions with the Bureau of Health Promotion and Section for Healthy Families and Youth.

Notes - 2010
Source: Missouri Information for Community Assessment (MICA)-Births, DHSS Vital Statistics. Provisional 2010 data as of March 2011. Final 2010 data will be available in early 2012.

To be consistent with the definition used by MICA, starting from 2010 data, the denominator has been changed from including total live births to only including live births with known prenatal care status.

In addition, MO started using the 2003 revision of Birth Certificate in 2010. The percentage of early prenatal care from the 2003 revision is not comparable to that collected using the earlier revision due to a change in how prenatal care is reported in the 2003 revision. A decline in the percentage of early prenatal care has been reported in states following the implementation of the 2003 revision.

An annual increase of 0.2% is used to create objectives 2011-2015, based on discussions with the Section For Healthy Families and Youth, MO DHSS.

Notes - 2009
Source: Missouri Information for Community Assessment (MICA)-Births, DHSS Vital Statistics. Provisional 2009 data as of April 2010. Final 2009 data will be available November 2010.

Numerator and denominator for 2008 are updated with 2008 final data. The proportion of early prenatal care in Missouri has been consistently above the national level. Mirroring the national

trend, the percentage in this indicator in Missouri had shown a small but noticeable decline for three consecutive years 2006-08. However, MO's 2009 provisional data showed a slight increase compared with the 2008 data. Hopefully this is the start of further improvement in this measure.

An annual increase of 0.2% is used to create objectives 2010-2014, based on the general increasing trend 1990-2009 and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
Safety net providers such as FQHCs provide many services to pregnant women in low income and underserved areas of the state. During 2010 8,640 prenatal patients were seen at these centers of which 5,157 women received prenatal care during their first trimester at the center and 434 reported receiving care during their first trimester with another provider. FQHCs have primary and satellite locations across Missouri and are charged with treating vulnerable populations; 95.7% of patients served in 2010 had an income of less or equal to the 200% Federal Poverty Level.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FQHCs provide safety net services.	X			
2. The OPCRH will continue offering health professional loan and loan repayment programs and assisting FQHCs with securing primary health care professionals.				X
3. Local Public Health Agencies (LPHAs) provide prenatal testing, counseling and referral to OB providers for early prenatal care; some provide prenatal case management.			X	
4. Majority of LPHAs screen and provide Temporary MO HealthNet During Pregnancy (TEMP), Medical Eligibility for pregnant women and referral for entry into early prenatal care.			X	
5. TEL-LINK, the toll-free information and referral line for MCH services provide prenatal referrals to callers through their local public health agency, community health center and pregnancy assistance providers to obtain a prenatal care provider.			X	
6. Women who enroll in the MCBHV and NFP HV programs are assessed for prenatal care. Women not receiving care are assisted to enroll in care. All women are educated on importance of prenatal care and keeping appointments; compliance is tracked.		X		
7. Customized Text4baby messages are provided to women who enroll educating them on the importance of prenatal care and provided resources to assist in obtaining services.			X	
8. Baby Your Baby Books were distributed to health care providers, health educators and MO families through the DHSS warehouse and statewide/regional exhibits.			X	
9. In 2011 the DHSS program distributed 31,897 Baby Your Baby Books in English; 2,545 Baby Your Baby Books in Spanish; and 38,544 developmental sheets with information for children from birth to 2 years of age .			X	
10.				

b. Current Activities
All activities listed in Table 4a will be continued.

The OPCRH is providing funding to 48 nurses and 39 physicians to serve in designated health professional shortage areas.

MCH Services contracts with LPHAs added preventing and reducing adverse birth outcomes as a new priority health issue. LPHAs addressing adverse birth outcomes are assessing hospitals on incidence of preterm births and possible contributing factors; continuing active coalitions working with high-risk teen moms; providing prenatal case management; working with clients, Medicaid, and OB providers to find out why pregnant women are not applying for full prenatal Medicaid benefits after being issued a temporary Medicaid card by LPHA.

The Baby Your Baby Website http://health.mo.gov/living/families/babies/babyyourbaby/index.php), Baby Your Baby Books provide information for pregnant women, their families, and communities about the importance of early and regular prenatal care. Baby Your Baby Books are distributed to health care providers, health educators and Missouri families through the DHSS warehouse and at statewide and regional exhibits.

c. Plan for the Coming Year
All activities listed in Table 4a will be continued.

LPHAs will be sharing assessment findings with community partners and developing strategies such as incentive programs for early entry into prenatal care, advocate for community policies that affect birth outcomes and expand prenatal case management to all prenatal clients.

A Missouri-specific booklet will be developed to include information about the importance of early and regular prenatal care.

D. State Performance Measures

State Performance Measure 1: *Percentage of women aged 18-44 years who are current cigarette smokers*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				24.4	24.6
Annual Indicator		28.4	24.5	24.7	28.6
Numerator		304229	261195	261882	302016
Denominator		1072890	1066101	1060251	1057845
Data Source		MO Behavioral Risk Factor Surveillance System	MO Behavioral Risk Factor Surveillance System	MO Behavioral Risk Factor Surveillance System	MO Behavioral Risk Factor Surveillance System
Is the Data Provisional or Final?				Final	Provisional

	2012	2013	2014	2015	2016
Annual Performance Objective	28.4	28.2	28	27.8	27.6

Notes - 2011
Source: Missouri Behavioral Risk Factor Surveillance System (BRFSS).
The percentage of current smoking among women 18-44 years of age increased from 2010 (24.7%) to 2011 (28.6%).
There is no cause for alarm as this jump is primarily due to NEW Weighting methodology adopted this year.

In 2011, the BRFSS used raking as the only source of data weighting.Raking represents an enhancement over previous post stratification weighting procedures.

Notes - 2010
Source: Missouri Behavioral Risk Factor Surveillance System (BRFSS). The percentage of current smoking among women 18-44 years of age decreased from 2008 (28.4%) to 2009 (24.5%), and essentially unchanged in 2010 (24.7%).

A slight decrease of 0.1% per year since 2010 was chosen for objectives 2011-2015, with considerations of the trend data and discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2009
The percentage of current smoking among women 18-44 years of age has been consistently higher in MO than in the US (24.5% vs. 18.4% in 2009). The percentage in MO decreased for four consecutive years from 31.6% in 2001 to 26.7% in 2005. Unlike the continuing declining trend in the nation since then, MO had seen a slight increase in this measure from 2005 to 2008 (28.4%). Although MO's 2009 percentage of 24.5% showed a noticeable decrease compared with the 2008 figure, it is too early to say if this is the one-year data fluctuation or indicates a further decline in this measure.

A slight decrease of 0.1% per year since 2010 was chosen for objectives 2010-2014, with considerations of the trend data and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
From October 2010 to September 2011, comprehensive smoke-free ordinances were implemented in Maryville, Warrensburg, Fulton, Brentwood, Creve Coeur, Jefferson City, Springfield and O'Fallon. From October 2010 to September 2011 the Quitline service to women was as follows: 4,038 women with 91 pregnant, 42 planning a pregnancy, and 16 currently breastfeeding at the time of the call . (Women comprise two-thirds of all Quitline tobacco user callers and individuals from 18 to 50 comprise more than 60% of all tobacco user callers.)

After four years addressing tobacco prevention, LPHAs through the MCH Services contracts reported community changes in attitudes regarding tobacco usage and more support of smoking bans, awareness of the health hazards related to smoking, more worksite wellness programs addressing cessation and second hand smoke with businesses contacting LPHAs for cessation classes for their employees. An increasing number of schools adopted and enforced smoke free campus policies.

During FFY11 the CCHC program provided 196 hours of training/consultation regarding asthma/environmental hazards/second-hand smoke within child care facilities to 1,183 staff/parents; and 31 health promotions to children. Consultants assisted in the development of

14 asthma action plans (AAPs).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LPHAs provide avoidance education through community campaigns, peer counseling in schools with Smoke Busters, TATU, NOT (Not on Tobacco), TAR Wars, second hand smoke education with WIC clients and advocacy for smokefree policies in communities.		X	X	
2. LPHAs provide or support cessation education in their communities with Freedom from Smoking, Brief Smoking Cessation/5 A's, Road to Freedom, resources for cessation products and referrals to the Missouri Quit Line.		X	X	
3. CCHC group training on the risks of smoking and second-hand smoke.		X		
4. CCHC assisted in the development of Asthma Action Plans.		X		X
5. All women enrolled in MCBHV and NFP home visiting programs are screened for smoking and educated on dangers of smoking and secondhand smoke to health and baby's health. Positive screens are referred to Quit Line and assisted with smoking cessation.		X		
6. "It All Counts" Facebook page provides information on the dangers of smoking . The same messages are shared through radio ads.			X	
7. The Baby Your Baby Website, Baby Your Baby Keepsake Books, and educational brochures in English, Spanish, Vietnamese and Chinese provided information about smoking cessation during pregnancy.			X	
8. MO Tobacco Quitline provides coaching to assist with cessation.	X	X		
9. DHSS staff provide technical assistance to LPHAs interested in pursuing smoke-free policies/ordinances.		X		X
10. Medicaid Managed Care Plans provide Quitline and Smoking Cessation Program information to members.	X	X		

b. Current Activities
All activities listed in Table 4b will be continued.

In January 2012, a comprehensive smoke-free ordinance was implemented in Rolla. From October 2011-September 2012 Quitline served 1,926 women: with 60 pregnant; 30 planning pregnancy; 4 currently breastfeeding.

LPHAs through MCH Services contracts have developed work plans using six levels of Spectrum of Prevention framework and LCP to prevent initiation of tobacco usage in school aged children, reducing tobacco use through evidence-based smoking cessation programs and reducing cigarette smoking consumption and second hand smoke exposures through implementation of tobacco or smoke-free environments.

CCHC program offers staff/parent training on hazards of smoking and second-hand smoke and children's health promotions. Referrals to smoking cessation programs are available upon request.

All women who enroll in MCH Block and ACA MIECHV funded home visiting programs will be screened for smoking on enrollment and at intervals throughout enrollment in programs. They will be educated on dangers of smoking to their health, health of baby and dangers of secondhand smoke. Those who screen positive are referred to Quitline and assisted with smoking cessation. Through ACA MIECHV program data will be collected on percentage of participating pregnant women who use tobacco during pregnancy.

c. Plan for the Coming Year
All activities listed in Table 4b will be continued.

St. Genevieve County will be promoting smoke free automobiles with their child passenger seat safety program.

State Performance Measure 2: *Percent of cigarette smoking among high school students.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	17.4	23.3	22.8	18.7	18.5
Annual Indicator	23.8	23.8	18.9	18.9	18.9
Numerator	68127	67789	53275	52767	52767
Denominator	286247	284830	281879	279188	279188
Data Source		Missouri Youth Risk Behavioral Survey	Missouri Youth Risk Behavioral Survey	Missouri Youth Risk Behavioral Survey	Missouri Youth Risk Behavioral Survey
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	18.3	18.1	17.9	17.7	17.5

Notes - 2011
Source: YRBS is conducted biannually. MO did participate in YRBS, but do not achieve a high enough overall response rate to receive weighted results. Therefore, their results are not posted on the CDC web site and CDC does not distribute their data. Annual indicator is percentage from 2009 CDC's YRBS data used as a proxy for 2011.

Notes - 2010
Source: YRBS is conducted biannually. Annual indicator is percentage from 2009 CDC's Youth Risk Behavioral Survey (YRBS) "Percentage of high school students who smoked cigarettes on one or more of the past 30 days. Denominator is estimate using number of fall enrollment grades 9-12 for school year 2009-2010 obtained from the MO Dept. of Elementary & Secondary Education. Numerator is based on percentage and denominator.

An annual decrease of 0.2% was chosen for objectives 2011-2015, based on trend data 1995-2009 and discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2009
Source: Annual indicator is percentage from 2009 CDC's Youth Risk Behavioral Survey "Percentage of high school students who smoked cigarettes on one or more of the past 30 days. Numerator is based on percentage. Denominator is estimate using number of fall enrollment grades 9-12 for school year 2008-2009 obtained from the MO Dept. of Elementary & Secondary Education.

An annual decrease of 0.2% was chosen for objectives 2010-2014, based on trend data 1995-2009 and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
From October 2010 to September 2011 comprehensive smoke-free ordinances were implemented in Maryville, Warrensburg, Fulton, Brentwood, Creve Coeur, Jefferson City, Springfield, and O'Fallon. The Smokebusters Program was modified and enhanced with a new leadership program for youth called Students with a Goal (SWAG). The first SWAG was designed and delivered in June 2011 by youth (Show-Me PALS - People Advocating Living Smokefree) under the guidance of adults. Through September 2011, 236 youth have been through SWAG leadership training. Comprehensive Tobacco Control Program (CTCP) staff assisted in Smokebusters and SWAG training (statewide and regional). In addition, 82 schools participated in the Smokebusters youth tobacco prevention program with 840 Missouri students getting trained. Those students educated 10,027 children and 13,715 adults on the dangers of tobacco use by youth tobacco prevention programs and promoted and implemented 13 smokefree policy changes including 12 school campuses and one town's public parks.

Last year LPHAs evaluated their past four years of effort addressing tobacco. Findings show increased collaboration with schools with both avoidance and cessation programs, the formation of anti-tobacco clubs, an increase in the number of and participation in cessation programs, more smoke free campuses and efforts expanded into serving at-risk youth involved in the juvenile justice system. The number of local businesses implementing smoke free policies continued to increase.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LPHAs collaborate with schools to implement best practices that involve education on advocacy for smoke free policies in schools and communities and peer-counseling. (Smokebusters Youth Groups, TATU, Students with a Goal, etc.)			X	
2. Through the FTM grant's "It All Counts" Facebook page, education is provided on the dangers of smoking. The same messages are also shared through radio ads.			X	
3. An Ounce of Prevention high school curriculum for family and consumer sciences, health and biology classes addresses the dangers of tobacco use and the importance of smoking cessation.			X	
4. LPHAs provide Freedom from Smoking classes to high school students who smoke.	X			
5. Social media messaging about smoking used by state and local health departments.		X	X	
6. LPHAs and Healthy Start grantees work with healthcare	X	X	X	

providers and FQHCs to provide smoking education and cessation programs.				
7.				
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4b will be continued.

In January 2012 a comprehensive smoke-free ordinance was implemented in Rolla . Currently 21.4% of Missouri's population lives in communities with comprehensive smoke-free ordinances.

AHP and Comprehensive Tobacco Control Program are collaboratively supporting positive youth development strategies statewide and supporting a youth track at the National Smoking or Health Conference in Kansas City in August 2012 .

LPHAs have begun utilizing social media through Face Book to reach this population with tobacco messages. Taney County HD is empowering change in the social norm by decreasing acceptability among youth as related to tobacco use.

Students registered for the National Conference on Tobacco or Health in Kansas City, MO in August 2012 include 10 MO college students, 16 MO high school students and 6 mentors of high school students.

Four youth from Missouri were selected to attend a youth advocacy symposium on July 15-19 at George Washington University (Washington, D.C.).

c. Plan for the Coming Year
All activities listed in Table 4b will be continued.

The School Health Program will assure that topics related to youth and tobacco are included in the Coordinated School Health Conference.

State Performance Measure 3: *Percentage of live births to women who are prepregnancy overweight or obese*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				47.7	47.4
Annual Indicator		47.2	47.9	47.5	47.9
Numerator		35897	35368	35738	34515
Denominator		76010	73910	75247	72034
Data Source		MO Birth Data	MO Birth Data	MO Birth Data	MO DHSS.Vital Statistics-Birth Data
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**

Annual Performance Objective	47.4	47.3	47.2	47.1	47

Notes - 2011
Source: MO DHSS Vital statistics-Births.
Numerator and Denominator is provisional 2011 data as of March 2012. Final data will be available in early 2013.
Numerator and denominator for 2010 updated with 2010 final data.

Objectives 2012-2016 based on trend analysis and discussions with the Section for Healthy Families and Youth, MO,DHSS.

Notes - 2010
Source: MO DHSS. Birth data, Missouri Vital statistics.
MO started using the 2003 revision of birth certificate in 2010.Numerator and Denominator is provisional 2010 data as of March 2011. Final data will be available in early 2012.
Numerator and denominator for 2009 updated with 2009 final data.

The percentage of births to women with prepregnancy overweight or obesity had been around 47.5% in the past three years from 2008 to 2010 (provisional data). An annual decrease of 0.1% has been chosen for objectives 2011-2015, based on discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2009
Source: MO DHSS. Birth data, Missouri Vital statistics.
The percentage of births to women with prepregnancy overweight or obesity had gradually increased from 41% in 1999 to 47.8% in 2009 (provisional data). An annual decrease of 0.1% has been chosen for objectives 2010-2014, based on discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
After four years addressing obesity prevention, LPHAs through the MCH Services contracts reported an increased number of schools changing vending machine foods to healthier choices, increased collaboration with local government to promote increased opportunity for physical activity, community gardens, and healthy nutritional choices; improved relationships with schools as a resource and partner; increased interest and participation from community partners building sustainability to continue addressing this issue; increased number of people using walking trails and parks for physical activity. Ozark County reported the lard display in their main grocery store dwindled, while the shelf of olive oil expanded. These were signs of changing social norms as it was becoming "cool" in that county to live a healthy lifestyle. At a Head Start in Phelps County teachers reported the children encouraged their parents to let them have a garden at home and asked to eat their garden food at lunch. This effort changed families' attitudes to include vegetables in their diets. Knox County, a rural community, built a community center for all residents that houses fitness and nutrition education.

Through the Chronic Disease Primary Prevention (CDPP) Program, counties successfully made policy and environmental changes that improved access to healthy food and safe places to be physically active which are both important for maintaining a healthy weight. Changes made included introducing community gardens, establishing joint use agreements with public facilities and leveraging CDPP funding for building community trails. The CDPP program contractors were also successful in carrying out community wide campaigns such as physical activity challenges and weight loss competitions to promote a healthier lifestyle.

Missouri Livable Streets (LS) is a public-private partnership between the University of Missouri Extension, Missouri Department of Transportation, Department of Health and Senior Services and over 11 other organizations. An advocacy manual and engineering design guide were both

developed and disseminated in 2011. Seventeen communities now have completed street or livable street policies in place. This represents over 1.1 million Missouri residents. In addition House Concurrent Resolution (HCR) No. 23 was passed. HCR 23 declares support for Complete Streets (Livable Streets) policies and urges their adoption by all levels of governing bodies regarding the shared use of our roads and highways by motorists, bicyclists and walkers, recognizing it not only for its transportation benefits but also for its health benefits.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LPHAs/community collaboratives develop/promote community gardens at schools and low income housing in rural and urban locations and provide cooking classes on how to prepare fresh produce.			X	
2. Community collaboratives develop and promote safe walking trails, walking programs, worksite wellness and community weight loss challenges.			X	
3. LPHAs continue to work to develop Complete Streets for bicycle and walking lanes, new sidewalks and promote Safe Routes to Schools.			X	
4. CCHC group training to child care providers/parents of children in child care on nutrition and physical activity and parent training on breastfeeding.		X		
5. The home visitors through the MCBHV and NFP programs weigh all women on enrollment and throughout their pregnancy. Women are educated on proper nutrition.		X		
6. The PAMR programs reviews whether or not women who died while pregnant or within one year of the termination of the pregnancy were overweight or obese when they became pregnant.			X	
7. Medicaid Managed Care Plans provide health coaching for over 2,000 members including home/clinic visits.	X	X		
8. Medicaid Managed Care Plans do presentations at High Schools on the effects of obesity on health and pregnancy.	X	X		
9.				
10.				

b. Current Activities
All activities listed in Table 4b will be continued.

Fifty-one LPHAs through MCH Coordinated Services contracts are addressing obesity prevention with community partners utilizing the Spectrum of Prevention framework. Plans include assessing grocery stores and working with marketing strategies to promote healthier foods such as a kids zone in the stores marketing healthy snacks; jointly publishing recipes with sales of produce and increasing marketing of fresh produce; promoting walking trails; working with schools to provide more exercise opportunities; developing joint use agreements with schools to make gyms available to families during off hours; contacting farmers markets about marketing fresh produce to the community and retail stores and promoting farmers markets in the community; working with restaurants to put stickers by healthier food options available on menus; working with local government on complete streets; and leveraging additional funding to improve current walking trails.

In addition to the Livable Streets project, BHP is currently supporting two projects to increase

access to healthy food in our communities. The first is a healthy corner stores project in St. Louis County which is working to improve the choices available in corner stores in low socioeconomic status areas of the county. The second is the Live Well Restaurant initiative which is working to improve the awareness about healthy foods on menus. Tool-kits are being developed for each project.

c. Plan for the Coming Year
All activities listed in Table 4b will be continued.

The OWH is collaborating with the Center for Health Equity and all Divisions in DHSS to develop a standardized data set for all programs in DHSS. This will allow DHSS to collect data that will better determine inequities in health care for Missourians and allow DHSS programs to better identify and target populations most at risk for poor health outcomes. Will enhance Department's ability to not only collect but also evaluate and target inequities (due to gender, race, socioeconomic status).

Obesity prevention in child care will remain a priority health issue for the CCHC program. Training, consultation and children's health promotions regarding nutrition and physical activity will be offered to staff, parents of children enrolled in child care and children in child care. CCHCs also recognize the importance of breastfeeding as a strategy in addressing the CCHC priority health issue to prevent/decrease obesity in young children. The CCHC program will partner with the Child and Adult Care Food Program to offer specific trainings on nutrition and physical activity. Many women working in child care facilities are of reproductive age, making this information significant as it relates to reproductive health.

BHP plans to continue to expand the Healthy Corner Stores and Live Well projects. Additional training and technical assistance will be provided to counties across the state.

Three additional counties will be funded to carry out policy and environmental changes to improve access to healthy food and safe places to be physically active. One of these projects will focus on breastfeeding.

Missouri is continuing the Livable Streets project work, but narrowing the focus to the Bootheel/southeast region of the state. Additional funding is being sought.

State Performance Measure 4: *Percent of high school students who met currently recommended levels of physical activity.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	72.8	44.5	45.5	49.3	50.3
Annual Indicator	43.5	43.5	48.3	48.3	48.3
Numerator	124517	123901	136144	134848	134848
Denominator	286247	284830	281871	279188	279188
Data Source		Missouri Youth Risk	Missouri Youth Risk	Missouri Youth Risk	Missouri Youth Risk

		Behavioral Survey	Behavioral Survey	Behavioral Survey	Behavioral Survey
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50.3	50.3	51.3	52.3	53.3

Notes - 2011
Source: YRBS conducted biannually. Annual indicator is percentage from CDC's Youth Risk Behavioral Survey 2009 data used as a proxy for 2011.

MO did participate in YRBS, but do not achieve a high enough overall response rate to receive weighted results. Therefore, their results are not posted on the CDC web site and CDC does not distribute their data.

Notes - 2010
Source: YRBS conducted biannually. Annual indicator is percentage from CDC's Youth Risk Behavioral Survey 2009.
A response of 5 or more days to the survey item "During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day?" (Add up all the time you spend on any kind of physical activity that increases your heart rate and makes you breathe hard part of the time). Denominator is the number of enrollment of grades 9-12 during the 2009-2010 school year, obtained from the MO Department of Elementary and Secondary Education.

An annual increase of 1% was chosen for objectives 2011-2015, based on data 2005-2009 and discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2009
Source: Youth Risk Behavioral Survey (YRBS) 2009
A response of 5 or more days to the survey item "During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day?" (Add up all the time you spend on any kind of physical activity that increases your heart rate and makes you breathe hard part of the time). Denominator is the number of enrollment of grades 9-12 during the 2008-2009 school year, obtained from the MO Department of Elementary and Secondary Education.

An annual increase of 1% was chosen for objectives 2010-2014, based on data 2005-2009 and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
MCH Service program staff through CASH and Missouri Council on Activity and Nutrition (MoCAN) advocated for continued physical activity standards to the Department of Elementary and Secondary Education, resulting in reinstatement of process and resources standards.

Missouri continued to participate in the Safe Routes to School Program, which is administered through the Missouri Department of Transportation. Sixteen projects totaling $3.4 million were funded in 2011. In addition communities across the state participated in walk to school days and sponsored walking school bus programs.

As part of the Livable Streets (LS) partnership, seventeen communities now have Complete Streets or Livable Streets policies in place, as discussed in State Performance Measure 3. LS policies relate to the shared use of our roads and highways by motorists, bicyclists and walkers, recognizing it not only for its transportation benefits but also for its health benefits.

Counties participating in the Chronic Disease Primary Prevention Program (CDPP) were successful in training youth groups to become advocates for physical activity and nutrition issues and leveraging their funding to build community trails.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LPHAs work with schools and other partners to provide health fairs and walk/runs to increase awareness of importance of physical activity.			X	
2. LPHAs participate on School Health Advisory Committees and in development of school wellness policies.			X	
3. MCH staff participates on Council for Adolescent and School Health to impact policy change on physical activity requirements for schools at the state level.				X
4. The "It All Counts" Facebook page provides information on the importance of physical activity. Companion radio ads also promote the message.			X	
5. Medicaid Managed Care Plans provide health coaching for obese members.	X			
6. MO participates in Safe Routes to School Program administered by MO Department of Transportation.		X	X	
7.				
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4b will be continued.

LPHAs through MCH Coordinated Services contracts using the Spectrum of Prevention framework will be working with local school districts to advocate for following current recommendation by the MoCAN; assessing physical activity levels of school students; identifying walking routes and partnering with a local youth coalition to seek additional opportunities for physical activity in the community; forming walking groups with students and hosting a pedometer classroom contest; developing joint use agreements with schools; utilizing social media on Facebook; assessing barriers to participating in physical activity and safe routes to schools.

Missouri continues to support the Livable Streets initiative through July 2012 with federal funding. The program has provided technical assistance and training to at least 25 communities. A bimonthly e-newsletter is also being published to increase awareness about the work occurring.

The "It All Counts" Facebook page provides information on the importance of physical activity. Companion radio ads also promote the message. Pedometers are distributed through the Facebook page and at events promoting the page.

c. Plan for the Coming Year
All activities listed in Table 4b will be continued.

The School Health Program will provide school health advisory councils with best practices related to the importance of physical activity.

The Safe Routes to School program plans to work more closely with their current grantees to ensure completion of projects.

The Department will fund two counties to work on policy and environmental changes to increase access to healthy food and safe places to be physically active. These counties will be encouraged to put a focus on interventions that impact the MCH Performance Measures.

State Performance Measure 5: *Birth rate (per 1,000) among teenage girls aged 15-19 years*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				42.1	37
Annual Indicator		45.4	41.6	37.0	33.1
Numerator		9154	8496	7663	6845
Denominator		201433	204220	206847	206847
Data Source		MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics	MO DHSS. Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	32.9	32.6	32.3	32	31.7

Notes - 2011
Source: MO DHSS Vital Statistics-Birth data, U.S. Census Bureau, 2010 Population estimates. Numerator is provisional 2011 birth number to women age 15-19 years as of March 2012. Final data will be available early 2013. Denominator is 2010 population number being used as proxy for 2011.
Numerator and denominator for 2010 are updated with 2010 final birth number and 2010 population respectively.

The birth rate among girls 15-19 years of age in MO decreased from 37.0% in 2010 to 33.1 per 1,000 in 2011 (provisional), which decreased for three consecutive years 2009-2011.
An annual decrease of 0.3 per 1,000 is anticipated for objectives 2012-2016, based on trend analysis and discussions with the Bureau of Health Promotion and Section For Healthy Families and Youth.

Notes - 2010
Source: Missouri Information for Community Assessment (MICA)-Births, DHSS Vital Statistics, MICA-Population. MO started using the 2003 revision of birth certificate in 2010. Numerator is provisional 2010 birth number to women age 15-19 years as of March 2011. Final data will be available in early 2012. Denominator is 2009 population number being used as proxy for 2010. Final population data will be available in November 2011.

Numerator and denominator for 2009 are updated with 2009 final birth number and 2009 population estimate respectively.

The birth rate among girls 10-14 years of age in MO also slightly decreased from 0.5 per 1,000 in 2008 to 0.4 per 1,000 in 2010 (provisional).

The birth rate among girls 15-19 years of age in MO decreased from 41.6% in 2009 to 37.3 per 1,000 in 2010 (provisional), which decreased for three consecutive years 2008-2010. 2011-2015 objectives based on trend analysis and discussions with the Section For Healthy Families and Youth.

Notes - 2009
The birth rate among girls 15-19 years of age in MO was 42.1 per 1,000 in 2009 (provisional), which decreased by 7.3% compared with the rate in 2008 (45.4 per 1,000).

The Adolescent Health Program, MO DHSS is in the process of applying for several federal funded teen pregnancy prevention grants. Other organizations across the state are also planning for applying grants that support evidence-based teen pregnancy prevention initiatives and strategies to reach teens. Considering these efforts, MO expects to see a gradual decrease in teen birth rate in the next few years especially since the implementation of the potential programs in 2011.

a. Last Year's Accomplishments
See National Performance Measure 8.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. See National Performance Measure 8.				
2. Contracts with agencies serving 12-19 year olds in more than 20 high need communities in MO including agencies serving youth in foster care or residential centers.	X	X	X	
3. Continue process of evaluating PREP contractors and outcomes.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4b will be continued.

See National Performance Measure 8 .

Through the ACA MIECHV program, data will be collected to measure the percentage of non-pregnant women receiving optimal birth spacing and birth control information by year one of index child's age.

The "It All Counts" Facebook page continues to provide preconception health messages on the importance of planning for pregnancy. Various marketing activities including health fairs, presentation at schools are being done by LPHAs to increase the number of "fans" of the page.

c. Plan for the Coming Year

All activities listed in Table 4b will be continued.

See National Performance Measure 8.

GHC home visiting programs will educate teen mothers enrolled in the programs on the importance of optimal birth spacing between the birth of the index enrolled child and conception of the next child and how this relates to improved quality of life for both the mother and her family. Resources will be given to teen mothers to encourage this education as needed.

Through a contract with MU Institute of Public Policy, 4 evaluation methods have been developed and piloted (process, student survey/outcome, fidelity and community capacity). Lessons learned from the start-up period are informing needed changes to be approved by 3 IRBs (MU, DHSS, DSS) for the full implementation year.

State Performance Measure 6: *Percentage of women aged 18-44 years who visited a dentist or a dental clinic for any reason within the past year*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				64.4	65.1
Annual Indicator		64.2	64.2	65.1	65.1
Numerator		681467	681467	690223	690223
Denominator		1061625	1061625	1060251	1060251
Data Source		MO Behavioral Risk Factor Surveillance System	MO Behavioral Risk Factor Surveillance System	MO Behavioral Risk Factor Surveillance System	MO Behavioral Risk Factor Surveillance System
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65.2	65.2	65.3	65.3	65.4

Notes - 2011
Source: Missouri Behavioral Risk Factor Surveillance System (BRFSS).
Data is not collected in odd years. 2010 BRFSS data used as a proxy for 2011.
An annual decrease of 0.1% every two years was choosen for objectives 2012-2016, based on trend analysis and discussions with the Section for Healthy Families and Youth.

Notes - 2010
Source: BRFSS 2010
MO had seen a slight increase in the percentage of access to dental care among women 18-44 years of age from 64.2% in 2008 to 65.1% in 2010.

Since 2005, MO Medicaid has limited dental services to adults. The only exception population is pregnant women who can receive preventive services through Medicaid. Increasing capacity of

FQHC/Community Health Center dental services has been a priority in Missouri since 2008, and a slight increase in dental encounters is anticipated.

Notes - 2009
Source: BRFSS
Mirroring the national trend, MO had seen a decline in the percentage of access to dental care in the past year among women 18-44 years of age from 70.7% in 2004 to 64.2% in 2008 (the most recent data).

Since 2005, MO Medicaid has limited dental services to adults. The only exception population is pregnant women who can receive preventive services through Medicaid. Increasing capacity of FQHC/Community Health Center dental services has been a priority in Missouri since 2008, and a slight increase in dental encounters is anticipated to start from 2010.

a. Last Year's Accomplishments
The OPCRH assisted FQHCs with oral health care by collaborating with the Missouri Primary Care Association for recruitment of practitioners to provide primary health care in underserved areas. During 2010, 125,965 dental patients were seen at FQHCs for a total of 274,381 visits.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. FQHCs provide dental care.	X			
2. OPCRH promotes access to dental care through increased FQHC access.			X	
3. OPCRH provides health professional loan and loan repayment programs that increase access to primary health care in underserved areas and for vulnerable populations.				X
4. OPCRH assists FQHCs with health care by collaborating with the Missouri Primary Care Association for recruitment of practitioners to provide primary health care in underserved areas.				X
5. Some Local Public Health Agencies (LPHAs) have dental clinics, dental vans or partner with FQHCs for dental services in their communities.	X		X	
6. Women enrolled in the MCH home visiting programs are encouraged to see a dentist during their pregnancy for a check-up. Home visitors assist them in finding dental services in their area.		X		
7.				
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4b will be continued.

The OPCRH is providing funding to 8 dentists to serve in designated health professional shortage areas.

The Oral Health Program is collaborating with the Missouri Dental Association on expanding the public education campaign "Your Mouth is Talking. Are You Listening?" Messages will build on existing efforts to continue to address the importance of oral health to total health for Missouri citizens.

The Missouri Primary Care Association is developing perinatal oral health training and integration programs with the intention to train every dental and medical professional in every Missouri FQHC in the etiology and prevention of oral disease as well as the provision of dental services to pregnant women and their infants.

c. Plan for the Coming Year
All activities listed in Table 4b will be continued.

State Performance Measure 7: *Percentage of women with a recent live birth who reported taking a multivitamin or a prenatal vitamin four or more times per week in the month prior to pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					36.3
Annual Indicator		32.4	35.9	35.4	35.4
Numerator		24917	26859	25596	25596
Denominator		76992	74846	72208	72208
Data Source		MO Pregnancy Risk Assessment Monitoring System	MO Pregnancy Risk Assessment Monitoring System	MO Pregnancy Risk Assessment Monitoring System	MO Pregnancy Risk Assessment Monitoring System
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	36.1	36.3	36.5	36.7	36.9

Notes - 2011
Source: MO PRAMS Survey.
The 2011 estimated percentage of women with a recent live birth who reported taking a multivitamin or a prenatal vitamin four or more times per week in the month prior to pregnancy is not available yet. The 2010 data based on the 2010 Missouri PRAMS survey response is used as proxy for 2011. 2011 PRAMS data will be available January 2013. Numerator and Denominator based on weighted PRAMS data.

A gradual increase the percentage of taking a multivitamin prior to pregnancy was set up for objectives 2012-2016, based on discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2010
The 2010 estimated percentage of women with a recent live birth who reported taking a multivitamin or a prenatal vitamin four or more times per week in the month prior to pregnancy is

not available yet. The 2009 data based on the 2009 Missouri PRAMS survey response is used as proxy for 2010. 2010 PRAMS data will be available January 2012. Numerator and Denominator based on weighted PRAMS data.

A gradual increase the percentage of taking a multivitamin prior to pregnancy was set up for objectives 2011-2015, based on discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2009
Source: 2009 PRAMS survey.

a. Last Year's Accomplishments
Text4Baby messages to pregnant women included information on the importance of taking multiple vitamins and folic acid supplements daily.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Women enrolled in the MCBHV and NFP home visiting programs are educated on the importance of taking folic acid or a multivitamin with folic acid during pregnancy and preconceptually. Compliance is tracked.		X		
2. Messages on the “It All Counts” Facebook page educate women on the importance of taking folic acid or a multivitamin containing folic acid both preconceptually and throughout pregnancy. Companion messages are shared on radio ads.			X	
3. The Missouri Text4baby program includes text messages about the importance of taking a prenatal vitamin containing folic acid every day.			X	
4. The Baby Your Baby Website, Baby Your Baby Health Keepsake Books and educational brochures in English and Spanish provide information about the importance of taking a multivitamin or prenatal vitamin containing folic acid prior to pregnancy.			X	
5. A 2011 MO Birth Defects Prevention and Awareness Month governor’s proclamation included the importance of taking a multivitamin containing 400 micrograms (mcg) of folic acid daily preconceptionally/ interconceptionally to reduce birth defects risk.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4b will be continued.

Through the ACA MIECHV program, data will be collected for women who have taken vitamins including folic acid during inter-conception.

Teacher training on the third edition of An Ounce of Prevention curriculum, including the online

student and teacher tutorials, was presented as a pre-conference session at the 2011 Annual Conference of the Missouri Association of Career and Technical Education, Family and Consumer Sciences on July 24-25, 2011. Training included the importance of taking a multivitamin containing folic acid as part of a healthy lifestyle. Participating teachers received a free copy of the curriculum and implemented student pretests and posttests to evaluate the effectiveness of the third edition.

Regional Educator Training on An Ounce of Prevention was conducted in five locations throughout the state during October and November 2011. All training included the importance of taking a multivitamin containing 400 mcg of folic acid daily. Participating teachers received a free copy of the curriculum and are submitting student evaluation feedback by April 30, 2012. The curriculum will be featured in a breakout session at the Teen Pregnancy and Prevention Partnership (TPPP) 2012 Conference on May 11, 2012 and additional curriculum training will be conducted August 7, 2012 in West Plains, Missouri.

c. Plan for the Coming Year
All activities listed in Table 4b will be continued.

A Missouri-specific booklet will be developed to include information about the importance of taking a multivitamin or prenatal vitamin containing folic acid prior to pregnancy.

Promote the "Planning for a Baby" brochure and other educational brochures in English and Spanish that will provide information about the importance of taking folic acid every day prior to and during pregnancy.

A governor's proclamation establishing January 2013 as Missouri Birth Defects Prevention and Awareness Month will include the importance of taking a multivitamin containing folic acid daily preconceptionally and interconceptionally to reduce the risk of birth defects. The campaign will include poster displays and statewide newsletter announcements.

State Performance Measure 8: *Percentage of women with a recent live birth who reported frequent postpartum depressive symptoms*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					16.1
Annual Indicator		12.2	16.5	13.8	13.8
Numerator		9279	12266	9820	9820
Denominator		75749	74186	71181	71181
Data Source		MO Pregnancy Risk Assessment Monitoring System	MO Pregnancy Risk Assessment Monitoring System	MO Pregnancy Risk Assessment Monitoring System	MO Pregnancy Risk Assessment Monitoring System
Is the Data Provisional or				Final	Provisional

Final?					
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	13.7	13.7	13.6	13.6	13.5

Notes - 2011
Source: MO PRAMS Survey.
The 2011 estimated percentage of women with a recent live birth who reported frequent postpartum depressive symptoms is not available yet. The 2010 data based on the 2010 Missouri PRAMS survey response is used as proxy for 2011. 2011 PRAMS data will be available January 2013. Numerator and Denominator based on weighted PRAMS data.

A gradual decrease of the percentage of postpartum depression was set up for objectives 2012-2016, based on discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2010
The 2010 estimated percentage of women with a recent live birth who reported frequent postpartum depressive symptoms is not available yet. The 2009 data based on the 2009 Missouri PRAMS survey response is used as proxy for 2010. 2010 PRAMS data will be available January 2012. Numerator and Denominator based on weighted PRAMS data.

A gradual decrease of the percentage of postpartum depression was set up for objectives 2011-2015, based on discussions with the Section For Healthy Families and Youth, MO DHSS

Notes - 2009
Source: 2009 PRAMS survey.

a. Last Year's Accomplishments
CCHC program conducted 54 hours of child care provider training and consultation on the topics of behavior/mental health/staff wellness.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Local Public Health Agencies (LPHAs) assess for postpartum depression and provide education and referrals during contacts with prenatal and postpartum women through home visits, prenatal case management visits and WIC.			X	
2. CCHC program provided training for child care providers on mental health/staff wellness.			X	
3. All women enrolled in the MCBHV and NFP home visiting programs are screened at 6 weeks and as indicated using the Edinburgh Screening tool for depression. Women who screen positive are linked to services.		X		
4. Customized text4baby messages educate women on the signs of perinatal depression and provide a referral source for women to obtain services through the Woman to Woman hotline.			X	
5. The Baby Your Baby Website, Baby Your Baby Keepsake Books and educational brochures distributed through the DHSS warehouse provide information about postpartum depressive symptoms.			X	
6. MO Medicaid Managed Care Plans provide information to members on postpartum depression.		X	X	

7. Medicaid Managed Care Plans follow up on all members who visit the ER with complaints of depression and encourage referral to a behavioral health provider.		X	X	
8. Medicaid Managed Care Plans provide gift cards to members who attended their postpartum healthcare visit.		X	X	
9.				
10.				

b. Current Activities
All activities listed in Table 4b will be continued.

Through the ACA MIECHV program, data will be collected for the percentage of mothers screened for postnatal depression at 4-8 weeks of index child's age.

c. Plan for the Coming Year
All activities listed in Table 4b will be continued.

CCHC program will offer general training on staff health and wellness including mental health and stress reduction. Intervention for depression is included and referral information made available.

A Missouri-specific booklet will be developed to include information about postpartum mood problems including depression.

Educational brochures with information about the causes and symptoms of postpartum depression as well as tips for prevention will be available for distribution from the DHSS warehouse.

State Performance Measure 9: *Percent of infants with permanent hearing loss and enrolled in appropriate early intervention services that are enrolled in those services by 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				72	78
Annual Indicator		69.6	62.0	50.0	70.8
Numerator		32	44	41	80
Denominator		46	71	82	113
Data Source		Missouri Newborn Hearing Screening Program	Missouri Newborn Hearing Screening Program	Missouri Newborn Hearing Screening Program	Missouri Newborn Hearing Screening Program
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual	72	72	72	73	73

Performance Objective					

Notes - 2011
Source: MO DHSS. Missouri Newborn Hearing Screening Program.
The percentage of Missouri infants with permanent hearing loss and enrolled in intervention services that were enrolled by 6 months of age significantly increased from 50.0% in 2010 to 70.8 % in 2011 provisional. Final 2011 data will be available in January 2013. The 2011 number represents babies born in 2010. A slight increase of 1% for every three years is anticipated for 2012-2016, based on discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2010
Source: MO DHSS. Missouri Newborn Hearing Screening Program.

The percentage of Missouri infants with permanent hearing loss and enrolled in intervention services that were enrolled by 6 months of age significantly increased from 62.0% in 2009 to 78.0 % in 2010 provisional. Final 2010 data will be available in January 2012. The 2010 number represents babies born in 2009. A slight increase of 1% for every two years is anticipated for 2011-2015, based on discussions with the Section for Healthy Families and Youth, MO DHSS.

Notes - 2009
Source: MO DHSS. Missouri Newborn Hearing Screening Program.

The percentage of Missouri infants with permanent hearing loss and enrolled in intervention services that were enrolled by 6 months of age significantly increased from 37.5% in 2005 to 65.7% in 2007, and continued to increase to 69.6% in 2008 (the most recent data). An annual increase of about 1% since 2009 has been chosen to set up objectives 2010-2014, with considerations of trend data 2005-2008 and discussions with the Section of Healthy Families and Youth, MO DHSS.

a. Last Year's Accomplishments
The MNHSP evaluated and continued to develop the MOHear Program. Changes included implementing the use of a "MOHear Checklist" which provided the First Steps Service Coordinator with the contact information of the MOHear who works in the child's region. This step ensured the SPOE knew who to contact for assistance.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Customized Text4baby messages remind mothers of the need for follow-up for infants who have a positive hearing screening at birth.			X	
2. Hearing Loss Parent Letter.		X		
3. Referral of infants diagnosed with permanent hearing loss to First Steps.		X		
4. Coordination with First Steps to obtain parent consent to share personally identifiable information with the MNHSP.				X
5. Sharing of data with First Steps in order to receive aggregate enrollment data.		X		
6. Recruitment of extended team members for National Initiative for Children's Healthcare Quality (NICHQ) Learning Collaborative and initiation of tests of changes aimed at improving hearing screening and intervention systems.			X	X
7.				

8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4b will be continued.

Continue statewide system of service coordination for the families of infants diagnosed with permanent hearing loss via the MOHear Program, administered through a contract with Missouri State University (MSU).

Coordinated meeting of Missouri parents of children with hearing loss in order to foment discussions regarding the development of a Hands and Voices parent/family support group in Missouri.

Provided training in recognizing and avoiding bias for parents involved in Hands and Voices start-up group and Missouri School for the Deaf personnel.

c. Plan for the Coming Year
All activities listed in Table 4b will be continued.

Continue to build System Point of Entry (SPOE) and MOHear Project relationship. Develop guidelines for collaboration with First Steps to clearly outline expectations of both programs in the Missouri EHDI process. Revise electronic audiologic diagnostic form to include client address updates.

State Performance Measure 10: *Percent of children ages 0-19 years old who received health care at a FQHC/CHC.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7.5	8.2	8.8	9.6	10.6
Annual Indicator	7.8	8.4	9.1	9.4	10.0
Numerator	123458	133248	145573	151032	160436
Denominator	1583410	1582696	1600883	1601411	1601411
Data Source		Missouri Primary Care Association	Missouri Primary Care Association	Missouri Primary Care Association	Missouri Primary Care Association
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	11.6	12.6	13.6	14.6	15.6

Notes - 2011
Source: Missouri Primary Care Association(MPCA).
Numerator 2011 data from Missouri Primary Care Association. Denominator 2010 population estimates 0-19 from U.S. Census Bureau, used as a proxy for 2011. 2011 population estimates will be available in November 2012.

An annual increase of 1% was chosen for objectives 2012-2016 based on trend analysis and discussions with the Section for Healthy Families and Youth.

Notes - 2010
Source: Missouri Primary Care Association(MPCA).
2009 final data used as a proxy for 2010. 2010 data will be updated in summer of 2012. Denominator is 2009 population estimate 0-19 from DHSS Missouri Information for Community Assessment (MICA), as proxy for 2010. 2010 population estimate will be available in November 2011.

Considering federal health care initiations to increase capacity of FQHC/CHC, an annual increase of 1% in the percentage of children receiving care through FQHC/CHC is anticipated.

Notes - 2009
Source: Numerator is 2009 data from Missouri Primary Care Association. Denominator is 2008 population estimate 0-19 from DHSS Missouri Information for Community Assessment (MICA), as proxy for 2009. 2009 population estimate will be available in November 2010.

Due to federal health care initiations to increase capacity of FQHC/CHC, an annual increase of 1% in the percentage of children receiving care through FQHC/CHC is anticipated to start from 2011.

a. Last Year's Accomplishments
Missouri has 21 FQHCs providing primary health care services through 182 community-based delivery sites. Currently community health centers serve the residents of 111 of Missouri's counties plus the City of St. Louis. During 2010 these sites served 392,785 individuals, a total of 1,447,405 visits. Of the patients served by community health centers, approximately 38% were age 19 and under.

The Primary Care Resource Initiative for Missouri (PRIMO) offers a multi-prong approach to strengthening the development and implementation strategies to define a system of coordinated health care services available and accessible to all Missourians. PRIMO investments made through the student loan component are crucial to assure identification, training and retention of Missouri's health care professionals that express an interest to serve in underserved areas of the state. PRIMO/ACCS (Access to Community Care Services), the community development and recruitment and retention components, are attentive to the immediate needs of expanding primary medical, dental and behavioral health care services. Providing financial and technical assistance to communities and health care professionals assures access to sustainable, affordable quality health care services. Due to decreased funding, the PRIMO/ACCS program, through investments in FQHCs, contributed 7,908 health care encounters to individuals of all age groups for FY2011.

School Nurses received information about FQHCs from School Health program.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community Health Centers provide primary care.	X			X
2. The Primary Care Resource Initiative for Missouri (PRIMO)			X	X

initiatives.				
3. Links to FQHCs are posted on the school health website.			X	X
4. Email messages about FQHCs sent to school nurses via email blasts.			X	
5. Local Public Health Agencies (LPHAs) refer individuals to FQHCs/CHCs as appropriate when services are needed.			X	
6. TEL-LINK, the toll-free information and referral line for maternal and child health services, provided health care referrals to Community Health Centers.			X	
7. School Health Program distributes information about FQHCs to school nurses.			X	
8.				
9.				
10.				

b. Current Activities
All activities listed in Table 4b will be continued.

The number of patient encounters attributed to PRIMO investments for FY2012 will not be available until January 2013.

c. Plan for the Coming Year
All activities listed in Table 4b will be continued.

E. Health Status Indicators

Introduction
Bureau of Health Informatics (BHI) is the primary source for health data within the state. BHI oversees the statistical support and health care monitoring activities of DHSS; collects, analyzes and distributes health-related information that promotes better understanding of health problems and needs in Missouri; and highlights improvements and progress achieved in the general health status of Missourians.

Data generated by the BHI aid and guide the planning, development and evaluation of programs and services of the department as well as the health-related activities of other agencies, institutions and organizations.

General services of the bureau include: maintaining the needed Vital Statistics infrastructure and data, providing specific statistical publications and preparing, editing and publishing other reports for the department, and disseminating this data via the web and other media.

Surveillance activities include: tracking selected indicators, disseminating data reports, analyzing and interpreting health data, and providing guidance as to how the data products are intended to be used.

/2013/BHI is now divided between BVS and BHCADD. The general purpose and function between the two bureaus remain the same.//2013//

LOW BIRTHWEIGHT:

Health Status Indicators 01A: The percent of live births weighing less than 2,500 grams.

Health Status Indicators 01B: The percent of live singleton births weighing less than 2,500 grams.

Health Status Indicators 02A: The percent of live births weighing less than 1,500 grams.

Health Status Indicators 02B: The percent of live singleton births weighing less than 1,500 grams.

Narrative:
Among the programs and activities which strive to improve the health of pregnant women and access to care and thereby reduce low weight births include: Missouri Community-Based Home Visiting, Nurse Family Partnership (Building Blocks of Missouri) Home Visiting, Alternatives to Abortions, TEL-LINK, Baby Your Baby website (www.health.mo.gov/babyyourbaby), Baby Your Baby Health Keepsake Books, Community Health Center, text4baby. For detailed activities of these interventions refer to National Performance Measure 18.

/2013/MCH Program used state data related to pregnancy and births to identify the new priority issue of preventing and reducing adverse birth outcomes for the FFY12-14 contract with LPHAs. Technical assistance provided by MCH regional nurses to LPHAs on how to access local data through MICA contract work plan development. Specifics can be found in Files Two and Three.//2013//

The Medicaid Managed Care programs in Missouri focus on various Performance Improvement Projects. All managed care programs focus on hi-risk obstetrics care on an on-going basis. Interventions include: 24 hour Nurse Hot Line/Info Line, Perinatal Nurse Telemanagement, Peer to Peer educational baby showers, specialty care such as gestational diabetes, 17 P, and Home Care as needed.

DEATHS -- UNINTENTIONAL INJURY:

Health Status Indicators 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Narrative:
The Safe Kids Coalitions implement a variety of prevention and intervention activities as described previously to reduce deaths due to unintentional injuries to children aged 14 years and younger. There were 684 injury prevention events serving over 80,000 children and their parents. Events included bicycle safety, water safety, fire/burn safety, and home safety.

/2012/The Safe Kids Coalitions participated in 428 injury prevention events serving over 55,000 children and parents. Events included bicycle safety, water safety, fire/burn safety, and home safety.//2012//

/2013/A new Safe Kids North West Coalition has been started and providing services in Mercer, Grundy and Nodaway Counties from March 2012. Columbia Safe Kids Coalition extended its services to Callaway County. As of current FFY 12, Safe Kids have conducted 260 health events, including 3 Child Passenger Safety trainings, and has reached 28,349 targeted audiences.//2013//

The Child Care Health Consultation (CCHC) Program provides consultation and education to child care providers regarding injury prevention in the child care setting. In FFY 2009, 244 hours of education/consultation on injury prevention topics was provided to adults and 578 injury prevention programs to young children.

/2012/In FFY 2010, the CCHC program delivered 328 hours of education/consultation on injury

prevention topics to adults and 255 injury prevention programs to young children.//2012//

/2013/In FFY 2011 the CCHC Program delivered 73 hours of adult training/consultation and 215 health promotions directed at young children on injury prevention.//2013//

MCH Services contractors (Local Public Health Agencies) address a variety of injury prevention activities including bicycle safety, life vests, and poisoning.

/2012/LPHAs addressed child passenger safety; gun, sun, home, farm, and fire safety; child life vest programs; fireworks, poisoning, skateboarding and ATV safety and safe sleep practices.//2012//

/2013/Buckle Up, Tween Safety, Back Seat Boss and Safety In and Around the cars are the campaigns which educate parents and caregivers on seat belt usage and hazards cars can pose to children like Hyperthermia/Heat stroke and Trunk entrapment.//2013//

/2013/MCH Program used state data related to unintentional injury to identify the priority issue of unintentional injury for the FFY12-14 contract with LPHAs. Technical assistance provided by MCH regional nurses to LPHAs on how to access local data through MICA contract work plan development.//2013//

/2013/Refer to National Performance Measure 10 for details of activities related to injury prevention in motor vehicle crashes which are also pertinent to this measure.//2013//

DEATHS - UNINTENTIONAL INJURY - DUE TO MOTOR VEHICLE:

Health Status Indicators 03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Narrative:
Numerous activities which include car seat and booster seat fitting stations/distribution/safety and campaigns to increase awareness of booster seat laws, promotion/distribution of life jackets for children 7 and younger at large recreational lake, ATV safety, bicycle safety and helmet use, and seat belt use are conducted throughout the state.

/2013/Buckle Up, Tween Safety, Back Seat Boss and Safety In and Around the cars are the campaigns which educate parents and caregivers on seat belt usage and hazards cars can pose to children like Hyperthermia/Heat stroke and Trunk entrapment.//2013//

/2013/Based on the data the MCH Services Program continues to address injury prevention due to MVA in the FFY12-14 contracts with LPHAs.//2013//

/2013/Through the customized Text4baby program women receive educational messages on car seat safety and are provided with a toll-free number to assist them in obtaining a car seat or installing a car seat properly.//2013//

/2013/Refer to National Performance Measure 10 for detailed activities related to this measure.//2013//

Health Status Indicators 03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Narrative:
The Bureau of Genetics and Healthy Childhood has developed a series of car seat safety cards

that are available to educate families on car seat safety. The series includes safety for adolescents.

DHSS contracts with ThinkFirst Missouri to provide education and resource information to middle and high school adolescents regarding head and spinal cord injuries. This program is called ThinkFirst for Teens. While the focus of ThinkFirst is directed towards reducing disabling injuries to the brain and spinal cord, the injury prevention messages conveyed are also effective in reducing the death rate from these injuries. A total of 67 programs were presented in 74 schools to 15,136 middle, junior, and high school students regarding spinal cord and brain injuries.

/2012/MCH Block Grant funding for ThinkFirst Missouri has been discontinued.//2012//

MCH Services contractors are addressing bicycle safety, life vests and poisoning and promoting seat best use through Battle of the Belts competition and Arrive Alive campaigns with high school students.

/2013/MCH Services contracts for FFY12-14 selected this issue as an ongoing priority due to success of interventions.//2013//

/2013/Injury and Violence Prevention program is working with MODOT on developing Missouri's Arrive Alive 2012-2016 Blue Print to Save More Lives. It contains strategies to reduce traffic crashes on Missouri roads, ultimately saving lives and reducing injuries.//2013//

/2013/Since McDonald County has a motor vehicle crash death rate of 47 per 100,000 compared to the state rate of 20 per 100,000 and ranks the second highest county in the state for driving while impaired; it is addressing injury prevention targeting motor vehicle and passenger safety with its MCH Services contract. County staff reported that injury prevention work was critical in their area due to lack of access to appropriate care. Because of the time it takes to transport patients who have been injured in any accident, particularly trauma with MVAs, to a facility that can care for these individuals (approximately 40 minutes), their risk of dying in route is greatly increased.//2013//

NONFATAL INJURY:

Health Status Indicators 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

Narrative:
Safe Kids Coalitions provide education, resources, and activities regarding car seat safety, bicycle safety, poisoning, water safety, safe home and school environments.

There were 684 injury prevention events serving over 80,000 children and their parents. Events included bicycle safety, water safety, fire/burn safety, and home safety.

The Child Care Health Consultation Program provides consultation and education to child care providers regarding injury prevention in the child care setting. In FFY 2009, 244 hours of education/consultation on injury prevention topics were provided to adults and 578 injury prevention programs were provided to young children.

/2012/In FFY 2010, the CCHC program delivered 328 hours of education/consultation on injury prevention topics to adults and 255 injury prevention programs to young children.//2012//

MCH Services contractors address bicycle safety, life vests, and poisoning.

Forty-one of the 112 Local Public Health Agencies serving 39 counties/cities are focusing on addressing injury prevention as their priority health need.

/2013/Forty-three LPHAs are addressing as a priority focus in FFY12-14 contract, based on their community data.//2013//

Collaboration with Special Projects of Regional and National Significance (SPRANS) has occurred and with the Traumatic Brain Injury (TBI) Demonstration Grant Program, which provides grants to States to implement systems that ensure access to comprehensive and coordinated TBI services. One of the target populations in Missouri is children acquiring a TBI between the ages of 0-4. The needs and resources assessment identified limited public knowledge of TBI as being a major barrier to services for the preschool population. The overall goal of the grant is "to provide individuals with traumatic brain injuries and their families with improved access to comprehensive, multidisciplinary, coordinated and easily accessible systems of care." Through this grant, the DHSS Bureau of Special Health Care Needs (SHCN) and Missouri Head Start are in the early stages of a partnership to provide education, training and information dissemination to increase public awareness and enhance service delivery to this underserved population. DHSS will continue to identify systems that provide services to this population and develop partnerships throughout this grant to work towards a comprehensive system of care for this population.

/2013/SHCN and the Missouri Head Start continued collaboration with input from Missouri Head Start on the development of materials to include in the concussion kits; further collaboration will take place to discuss dissemination of the concussion kits to all of the Head Start programs in Missouri.//2013//

/2012/SHCN collaborates with the Brain Injury Association of Missouri, the DHSS School Health Program, and DHSS Adolescent Health Program to disseminate information regarding the identification and management of youth sports concussions. Examples of the information distributed include newsletter articles and CDC Concussion Kits.//2012//

/2013/A total of 1500 CDC Concussion kits were disseminated to: Heads Up High School Program, Youth Sports Heads Up Program and ABC School Nurses Program.//2013//

/2013/GHC and the Children's Trust Fund developed a new educational video for expecting or new parents on Shaken Baby/Safe Sleep. The DVD has versions in English, Spanish, and close-captioned. This DVD meets the requirements of MO RSMo 191.748, which requires that all new mothers have an opportunity to view a video on the dangers of shaken baby syndrome before the mother's discharge from the healthcare facility after delivery.//2013//

/2013/See Health Status Indicator 03A.//2013//

NONFATAL INJURY -- DUE TO MOTOR VEHICLE:

Health Status Indicators 04B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

Narrative:
Safe Kids Coalitions provide education and resources for child passenger safety, instruction for proper car seat installation and use, and conduct car seat safety checks for children aged 14 years and younger. A total of 7,565 car seats were checked and/or distributed and child passenger safety information provided at 154 events during the year.

/2012/Safe Kids Coalitions continued providing safety education and resources to children under 15 years and to parents. More than 1,200 car seats were distributed in over 85 car seat

events.//2012//

/2013/A new Safe Kids North West Coalition has been started and providing services in Mercer, Grundy and Nodaway Counties from March 2012. Columbia Safe Kids Coalition extended its services to Callaway County. As of current FFY 12, Safe Kids have conducted 260 health events, including 3 Child Passenger Safety trainings, and has reached 28,349 targeted audiences.//2013//

In FFY 2009 the Child Care Health Consultation Program provided 19 hours of education/consultation regarding motor vehicle safety to child care providers.

/2013/In FFY 2011 the CCHC Program provided 10 hours of training/consultation regarding motor vehicle safety to child care providers.//2013//

Missouri Department of Transportation provides car seats to LPHAs participating in Safe Kids Coalitions and Arrive Alive campaigns with high schools.

MCH Services contractors are implementing programs for car/booster seats and seat belt use.

/2013/See Health Status Indicator 03B.//2013//

Health Status Indicators 04C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Narrative:
DHSS contracted with ThinkFirst Missouri to provide education and resource information to middle and high school students regarding head and spinal cord injuries. ThinkFirst for Teens provides an assembly program with an informative presentation, compelling testimony from a survivor, high-impact video, and an interactive question and answer session. A total of 67 programs were presented in 74 schools to 15,136 middle, junior and high school students regarding spinal cord and brain injuries.

/2012/MCH Block Grant fund for ThinkFirst Missouri has been discontinued.//2012//

MCH contractors promoting seat best use through Battle of the Belts competition and Arrive Alive campaigns with high school students.

/2012/Local Public Health Agencies (LPHAs) addressing texting while driving and drinking and driving.//2012//

/2013/The University of MO School of Health Professions has launched a resource for people to understand traumatic brain injuries. The Brain Injury Guide and Resources were developed through a collaboration with the DHSS Head Injury Unit. The website is designed specifically for people who come in contact with persons who have suffered brain trauma, such as police officers, social workers, and military personnel. Topics in the guide include understanding brain injuries, concussions, and expected behaviors. Funding for this project was partially provided by the DHSS TBI Grant.//2013//

/2013/See Health Status Indicator 03C.//2013//

CHLAMYDIA:

Health Status Indicators 05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

Narrative:
The Bureau of HIV, STD, and Hepatitis began a social marketing campaign in April 2009 using both MySpace and Facebook social networks. Over the past year it has become apparent that Facebook is more effective in promoting this program's messages. Information on relevant prevention and awareness materials including videos, links, documents, and discussion topics are posted. Information is also posted regarding events held throughout the state. Two paid Facebook advertising campaigns have been completed. The first campaign in December 2009 resulted in a 60% increase in fans/likers and a daily 100-200% increase in page views. In April 2010, four different ads were promoted for four weeks. The increase in fans/likers was not as significant as the December campaign. However, page views still represented a 400% increase over the average of the prior three months.

In March 2009, the Bureau of HIV, STDs, and Hepatitis launched its "Take Control, Take the Test" social marketing campaign targeting adolescent females. The campaign is meant to increase awareness of sexually transmitted diseases and to reduce the stigma associated with getting tested. A website was created (www.takethetest.info) that includes a test site locator and links to the Facebook and MySpace pages. Materials promoting the website were created by a public relations firm and used in schools, clubs, and other areas where adolescents congregate.

The State Public Health Lab performs approximately 80,000 gonorrhea and chlamydia tests per year. The majority of this testing is provided through the Missouri Infertility Prevention Project (MIPP) which focuses on the prevention and early treatment of chlamydial and gonococcal infections through the collaborative effort of health care providers. MIPP screens women 25 years of age and younger for Chlamydia annually. The overarching goal of MIPP is to lead a collaborative effort to prevent and reduce STD-related infertility.

Missouri is part of Region VII along with Kansas, Nebraska, and Iowa. Federal funds also support the regional advisory committees and their collaborative work, including the chlamydia prevalence monitoring surveillance system to monitor trends in disease and to evaluate program impact. The program works closely with high prevalence contracted sites to conduct screening, provide treatment, and conduct partner management. On average the MIPP program has 80 sites that conduct annual screening on women 25 years and younger; symptomatic males or those males who are known sexual contacts to infected patients.

The Adolescent Health Coordinator serves on the MIPP Advisory Committee that addresses screening and treatment of STDs. Several DHSS teams are collectively addressing prevention of STDs and teen pregnancy.

/2012/The Facebook, MySpace, and social marketing campaigns have been discontinued.//2012//

/2013/Facebook and other social media sources are available and utilized. AHP and Bureau of HIV, STD and Hepatitis collaborated on development of new chapters on STDs for An Ounce of Prevention curriculum resource.//2013//

/2013/The emphasis on social media as a conduit for sharing awareness information is reinstated through BHSH's collaboration with the Region XII MIPP Contractor. BHSH provides technical assistance for a web-based initiative, www.didjaknow.org, coupled with Facebook. MIPP efforts continue to allow thousands of Missouri women to have access to STD screening.//2013//

See Health Status Indicator 05B for other related activities which cross age boundaries.

Health Status Indicators 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Narrative:
The Missouri Community-Based and Building Blocks Home Visiting programs assess all women enrolled to determine if they have been previously been or currently diagnosed with Chlamydia and if they received treatment. Women enrolled in these programs are educated on sexually transmitted diseases and the effects they have on the current pregnancy and future fertility.

/2012/Missouri recognizes the need to identify and treat new cases of Chlamydia and the need to increase program efforts surrounding gonorrhea control to reduce the occurrence of Pelvic Inflammatory Disease (PID) and STD related infertility in all women regardless of age.

The Missouri Infertility Prevention Program (MIPP) Testing Coordinator and the Bureau's Health Educator(s) have collaborated to provide information regarding Center for Disease Control's (CDC) implementation of routine Chlamydia screening among non-MIPP providers. Information includes technical assistance, and periodic informative articles and newsletters.

MIPP was expanded to include the option of testing symptomatic females multiple times within the same calendar year regardless of initial test result or age. Cost saving measures were implemented by the State Public Health Laboratory which enabled the purchase of less expensive Ct/GC test kits, thus allowing for additional Ct/GC testing in walk-in pregnancy testing centers in the highest morbidity areas of the state.//2012//

/2013/ MIPP continues to provide a valuable screening resource for Missouri's women of child-bearing age.//2013//

See Health Status Indicator 05A for other related activities which cross age boundaries.

DEMOGRAPHICS:

Health Status Indicators 06A: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)

Narrative:
The estimated population in the 0 to 24 age group increased slightly from 1,980,780 in 2007 to 1,981,932 in 2008 (0.1%). The increase was observed among African-Americans (0.1%) and other (non-white 2.5%) race groups. The largest increase was among the 18 to 19 year olds (2.2%) and 1 to 4 year olds (2.1%). The total live births decreased by 1.2% from 2007 to 2008.

/2012/The estimated population in the 0 to 24 age group slightly decreased from 2,025,138 in 2008 to 2,023,792 in 2009 (0.1%). The slight decrease was among the 20 to 24 year olds (0.3%) and 5 to 9 year olds (0.6%). The total live births decreased by 2.6% from 2008 to 2009.//2012//

/2013/The estimated population in the 0 to 24 age group slightly decreased from 2,023,792 in 2009 to 2,014,700 in 2010 (0.4%). The decrease was among 20 to 24 year olds (2.3%) and 1 to 4 year olds (3.4%). Total live births decreased by 2.7% from 2009 to 2010.//2013//

Health Status Indicators 06B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)

Narrative:
The estimated population of Hispanics in Missouri under age 25 increased by 4.2% from 89,550 in 2007 to 93,280 in 2008. This compared to a slight decrease (0.1%) in the non-Hispanic population for the same age group. The increase in the Hispanic population was across all sub-age groups except for birth population, which showed a 3% decreased from 2007 to 2008.

/2012/The estimated population of Hispanics in Missouri under age 25 increased by 4.1% from 98,704 in 2008 to 102,751 in 2009. This compares with a slight decrease of 0.3% for non-Hispanic population estimate.//2012//

/2013/The estimated population of Hispanics in Missouri under age 25 increased by 5.9% from 102,751 in 2009 to 108,781 in 2010. This compares with a slight decrease of 0.8% for non-Hispanics.//2013//

Health Status Indicators 07A: Live births to women (of all ages) enumerated by maternal age and race. (Demographics)

Narrative:
Total live births decreased by 2.8% from 2008 to 2009 (provisional). The proportion of births to women under 18 was 6.4% in African-Americans and 2.5% in whites in 2009. Compared to the 2000 birth rate (per 1000) for all races, the 2008 birth rate decreased in teens under 18 while it increased across other age groups:
10-14: 0.7 (2000) vs. 0.2 (2008)
15-17: 26.7 (2000) vs. 21.6 (2008)
18-19: 80.4 (2000) vs. 83.1 (2008)
20-34: 104.3 (2000) vs. 107.7 (2008)
35-44: 18.5 (2000) vs. 21.2 (2008)

/2012/Total live births decreased by 3.6% from 2009 to 2010 (provisional). The proportion of births to women under 18 was 5.9% in African-Americans and 2.2% in whites in 2010.//2012//

/2013/From 2010 to 2011 (provisional), total live births decreased by 4.4%; African-Americans decreased by 1.9%; and whites decreased by 4.9% during the same time period.//2013//

Health Status Indicators 07B: Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)

Narrative:
The live birth rate in the Hispanic population decreased by 5% from 2008 to 2009 (provisional). The birth rate for women under 18 was 4.7% in Hispanics and 3% in Non-Hispanics in 2009. Compared to the 2000 Hispanic birth rate (per 1000), the 2008 rate decreased in teens age 15 to 17 and increased in the other age groups:
15-17: 48.6 (2000) vs. 47.1 (2008)
18-19: 118.4 (2000) vs. 154.9 (2008)
20-34: 137.8 (2000) vs. 161.7 (2008)
35-44: 31.9 (2000) vs. 37.3 (2008)

/2012/The live births in the Hispanic population slightly increased by 0.5% from 2009 to 2010 (provisional). The proportion of births to women under 18 was 3.6% in Hispanics and 2.7% in Non-Hispanics in 2010. //2012//

/2013/From 2010 to 2011 (provisional), live births in the Hispanic population decreased by 7.7%; non-Hispanic live births also decreased by 4.3%.//2013//

Health Status Indicators 08A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

Narrative:
Deaths of children age 0 to 24 decreased slightly from 1,544 (77.9 per 100,000) in 2008 to 1,497 (75.5 per 100,000) in 2009 (provisional). From 2008 to 2009 (provisional), the infant death rate (per 1,000) slightly increased in whites (5.9 in 2008 to 6 in 2009) while decreasing in African-Americans (15 in 2008 to 13.8 in 2009).

/2012/Deaths of children age 0 to 24 decreased slightly from 1,511 (74.7 per 100,000) in 2009 to 1,380 (68.2 per 100,000) in 2010 (provisional). From 2009 to 2010 (provisional), the infant death rate (per 1,000) decreased in both whites (6.1 in 2009 to 5.8 in 2010) and African-Americans (13.8 in 2009 to 11.9 in 2010).//2012//

/2013/Death rate (per 100,000) for children age 0 to 24 decreased slightly from 68.0 in 2010 to 66.2 in 2011. The overall infant death rate (per 1,000) also decreased from 6.5 in 2010 to 6.2 in 2011 (both 2010, 2011 data provisional).//2013//

Health Status Indicators 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

Narrative:
Deaths of Hispanic children age 0 to 24 decreased slightly from 46 (49.3 per 100,000) in 2008 to 45 (48.2 per 100,000) in 2009 (provisional). Hispanic infant deaths decreased slightly from 23 (5.1 per 1,000) in 2008 to 21 (4.9 per 1,000) in 2009 (provisional).

/2012/Deaths of Hispanic children age 0 to 24 decreased from 45 (43.8 per 100,000) in 2009 to 31 (30.2 per 100,000) in 2010 (provisional). Hispanic infant deaths decreased from 21 (4.9 per 1,000) in 2009 to 16 (3.7 per 1,000) in 2010 (provisional).//2012//

/2013/Death rate (per 100,000) for Hispanic children age 0 to 24 increased slightly from 43.2 in 2010 to 44.1 in 2011. The Hispanic infant death rate (per 1,000) also decreased from 4.6 in 2010 to 4.5 in 2011 (both 2010, 2011 data provisional).//2013//

Health Status Indicators 09A: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)

Narrative:
From 2008 to 2009, the number of children ages 0 to 19 receiving food stamps increased by 44,723 (9%). The number of Medicaid recipients in the same age group increased by 40,575 (8%). Although the overall high-school drop-out rate held steady at 4.2%, the African-American drop-out rate slightly increased from 9.0% in 2007 to 9.2% in 2008.

/2012/From 2009 to 2010, the number of children ages 0 to 19 receiving food stamps increased by 41,362(7.9%). The number of Medicaid recipients in the same age group increased by 14,739(2.7%). The overall high-school drop-out rate decreased from 4.2% in 2009 to 3.5 in 2010.//2012//

/2013/From 2010 to 2011 the number of children ages 0 to 19 receiving food stamps increased by 14,377 (2.6%). The number of SCHIP recipients in the same age group increased by 2,207 (1.8%). The overall high-school drop-out rate decreased from 3.5 to 3.4 percent; the white high-school drop-out rate decreased from 2.4% to 2.2%; and the African-American drop-out rate increased from 8.5% to 8.8%.//2013//

Health Status Indicators 09B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.

(Demographics)

Narrative:
Among children 0 to 19 years of age, the proportion of Hispanics increased from 4.8% in 2007 to 5% in 2008. This group represents 7% of the Medicaid recipients.

From 2007 to 2008, the proportion of Hispanics increased from 5.3% to 5.7% among children in SCHIP, and increased from 4.8% to 5.3% among children in the food stamp program. The rate per 100,000 of Hispanic juvenile crime referrals increased from 1,572 in 2007 to 1,598 in 2008.

/2012/From 2008 to 2009, the proportion of Hispanics increased from 5.7% to 5.9% among children in SCHIP, and increased from 5.3% to 5.7% among children in the food stamp program. The rate per 100,000 of Hispanic juvenile crime referrals decreased from 1,598 in 2008 to 1461 in 2009.//2012//

/2013/From 2010 to 2011 the proportion of Hispanics increased from 5.9% to 6.2% among children in SCHIP and increased from 5.7% to 5.9% among children in the food stamp program. The Hispanic high school dropout rate increased from 4.1 in 2010 to 4.8 percent in 2011.//2013//

Health Status Indicators 10: Geographic living area for all children aged 0 through 19 years.

Narrative:
The estimated percentage of children age 0-19 living in rural areas was 30.6% in 2008. This compares to 31.7% in 2007.

/2012/The estimated percentage of children age 0-19 living in rural areas was 30% in 2009. This is close to the 2008 figure 30.6%.//2012//

/2013/The estimated percentage of children aged 0-19 living in rural areas was 30% in 2010.//2013//

Health Status Indicators 11: Percent of the State population at various levels of the federal poverty level.

Narrative:
An estimated 31.9% of Missourians lived in households with income under 200% of federal poverty level in 2008. This compares to 30.5% in 2007.

/2012/The estimated percentage of Missourians living under 200% of federal poverty level slightly increased from 31.9% in 2008 to 33.7% in 2009.//2012//

/2013/The estimated percentage of Missourians living under 200% of the federal poverty level slightly decreased from 33.7% in 2009 to 31.8% in 2010.//2013//

Health Status Indicators 12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.

Narrative:
An estimated 39.1% of Missouri children age 0 to 19 lived in households with incomes under 200% of federal poverty level in 2008. This compares to 41.7% in 2007.

/2012/The estimated percentage of Missouri children age 0 to 19 living under 200% of federal

poverty level slightly increased from 39.1% in 2008 to 42.4% in 2009.//2012//

/2013/The estimated percentage of Missouri children age 0 to 19 living under 200% of the federal poverty level decreased from 42.4% in 2009 to 39.9% in 2010.//2013//

F. Other Program Activities

Text4baby

DHSS joined as an outreach partner with the National Healthy Mothers, Healthy Babies Coalition to promote text4baby, a free texting service that sends messages to participants' cell phones. The service will provide health information from pregnancy through a baby's first year. Plans are to distribute text4baby posters Local Public Health Agencies (LPHAs) and to include text4baby information as part of the other health education materials provided by the DHSS. As of April 30, 2010 there were 1,223 Missourians who had enrolled in the text4baby service.

/2012/Missouri was the first state to implement state specific messages. Also Missouri has initiated a campaign "SHOW ME" We Can Do It to encourage partners statewide to participate in the Text4baby enrollment contest.//2012//

/2013/Between February 10, 2010 and September 30, 2011, 7,982 Missouri women enrolled in the Text4baby service.//2013//

TEL-LINK

TEL-LINK is the Department of Health and Senior Services' (DHSS) confidential, toll-free information and referral line for maternal, child and family health services. Callers are given referrals and are transferred immediately to the appropriate agency. During FFY2010, the TEL-LINK number was posted on the DHSS website for "Perinatal & Postpartum Depression."

Outreach is provided through the TEL-LINK website, exhibits at conferences and health fairs and through advertising in various parenting and health magazines to promote TEL-LINK. The program was promoted for the first time this year at a Women's Correctional Center's health fair. Collaboration with other programs, such as Missouri Head Start, has allowed the TEL-LINK number to become known to head start agencies throughout the state.

/2012/In FFY 2011, resources for Pregnancy Assistant Providers and Fetal Ultrasound Providers were added. The TEL-LINK number is also posted on the website under these providers.//2012//

/2013/In FFY 2011 the TEL-LINK Program answered 3,042 calls and participated in the Fulton State Hospital Employees Health Fair where approximately 450 employees attended. Literature on healthy births and babies was distributed. Additional resources on food banks were added to the TEL-LINK database to assist Missouri families.//2013//

Parenting Corners

Genetics and Healthy Childhood (GHC) is funding the construction of 21 Parenting Corners for distributing parenting materials to Department of Corrections (DOC) offenders at 21 facilities as part of the DOC Restorative Justice Reentry Program. GHC will contribute literature including Basic Child Development, Safety, Exercise and Nutrition, Mental Health, Substance Abuse/Prevention, Education, Special Populations, and Legal. Each Parenting Corner will also feature a drop-box where offenders can submit specific questions. The first Parenting Corner was ready for placement May 1, 2010.

/2013/In FFY 2011 there were 25 Parenting Corners at DOC facilities.//2013//

Denim Day

Denim Day is an annual, international rape education and awareness campaign. The DHSS, Office on Women's Health (OWH) coordinates Denim Day in Missouri and supports the organizations participating by furnishing Denim Day toolkits, lapel pins, bookmarks, flyers and posters along with technical assistance free for Missouri participants. There were over 310 events across Missouri in 2010 with colleges/universities, junior high/high schools, State Departments, Local Public Health Departments, not-for-profit agencies, Army and Air Force Bases and private businesses participating. The Denim Day website www.supportdenimday.com,Twitter and Facebook presence is utilized to promote Denim Day.

/2012/OWH continues the annual Denim Day event.//2012//

/2013/OWH again coordinated the annual Denim Day event April 26 2012. OWH offered technical assistance and supply materials to many organizations across Missouri to educate and inform Missourians on primary prevention tools to prevent rape and sexual violence. Over 300 events were held across the state.//2013//

SAFE-CARE

SAFE-CARE (Sexual Assault Forensic Examination-Child Abuse Resource and Education) Network, administered by DHSS and supported by a Medical Director and Advisory Council, provides training and support to physicians***/2013/, physician assistants,//2013//*** and nurse practitioners who conduct medical evaluations of alleged victims of child maltreatment.

/2012/The Medical Director position ended on 4/30/10 with the expiration of the Consulting Services contract.//2012//

/2013/A new Consulting Services contract was awarded on 5/4/11 and medical directors were established at all three child abuse medical resource centers.//2013//

Women's Health

The Office on Women's Health Network is comprised of organizations and individuals concerned with women's health. The Network provides timely information about current issues in women's health, such as changes in services for women, changing technology in women's health, funding opportunities, resources, and pertinent state legislative updates. It reaches every county in the state.

Health Literacy

In December 2009, Health Literacy Missouri (HLM), the nation's first statewide center devoted solely to increasing health literacy opened for business in St. Louis. The mission of HLM is to improve the health of all Missourians by providing access to plain language healthcare information, offering educational resources that help healthcare providers communicate effectively with patients, creating systematic change at the point of medical care, improving health literacy through education and community collaborations, and strengthening the evidence base for health literacy. The group's website, www.healthliteracymissouri.org, provides users free access to an online library of health literacy materials.

/2013/The Bureau of Genetics and Healthy Childhood's newborn health and newborn screening programs use health literacy in developing materials. The newborn hearing program also trained their staff on communicative strategies on health literacy to assist them in communicating more effectively with parents.

Section of Special Health Services (SHS) contracts with a LPHA for implementation of the Family Partnership Initiative. The LPHA employs four Family Partners who are chosen for their expertise as parents or caregivers of individuals with special health care needs. In an effort to assure utilization of plain language, materials developed by SHS are distributed to Family Partners and family members for review and feedback. SHS revises materials based on feedback to assure high quality materials are available for SHS participants and families.//2013//

/2013/Breastfeeding Program

The Breastfeeding Program protects, promotes and supports exclusive breastfeeding initiation and continuation guidelines as recommended by the American Academy of Pediatrics (AAP) and as supported by the Healthy People 2020 breastfeeding goals and the Surgeon General's Call to Action to Support Breastfeeding.//2013//

/2013/CCHC Program Evaluation

The statewide Child Care Health Consultation (CCHC) Program is a population-based public health program based upon a professional nursing model and is the largest network of Missouri trainers that direct efforts toward preschool children enrolled in child care settings. Trainings include approved clock hours (licensed child care facilities' staff must have 12 clock hours annually) that are offered free of charge. A recent outside evaluation of the CCHC Program included an assessment of program operations and contractual processes; assessment of financial performance; and a survey of attitudes and expectations of local public health agencies (LPHAs). Evaluation results reinforced the value of this initiative by participating LPHAs and also provided input for future program development to reduce the volume of paperwork and include outcomes.//2013//

G. Technical Assistance

Technical assistance requests under consideration include:

-Implementation of the "Lifecourse" perspective. Missouri has chosen to implement the "Lifecourse" perspective as the overarching theme for the 2010 State Priorities. It became apparent as part of the needs assessment process that the "Lifecourse" perspective was a method of addressing each of Missouri's priority needs as opposed to a specific priority of its own.

-Expansion of Medical Home. Much has been written and discussed regarding MH in Missouri. Missouri has utilized several "factors" in selecting a best measure of "promotion of medical home", such as how many children have a primary care provider listed. Technical assistance from an outside source, such as the American Academy of Pediatrics, is being requested to identify specific measures of "medical home" to determine the "best" measure of "promotion of medical home" in Missouri.

- Healthy Birth Outcomes/Infant Mortality. Technical Assistance is needed to identify challenges in programs, agencies and/or policies to allow for corrective action and address Missouri 2010 Priority Needs of reducing disparities in adverse birth and pregnancy outcomes and reducing intentional and unintentional injuries among infants.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	13236586	10743435	11718061		11726020	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	12036562	5916543	12292784		12843247	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	4000	0	6500		8000	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	25277148	16659978	24017345		24577267	
8. Other Federal Funds *(Line10, Form 2)*	177154471	171738239	175233681		178344362	
9. Total *(Line11, Form 2)*	202431619	188398217	199251026		202921629	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	3114394	1967367	2930073		1825465	
b. Infants < 1 year old	3503169	2453857	2870315		2900353	

c. Children 1 to 22 years old	10259805	4790069	4525547		4435334	
d. Children with Special Healthcare Needs	6360423	6161504	5367657		6958520	
e. Others	742171	449858	7155073		7317748	
f. Administration	1297186	837323	1168680		1139847	
g. SUBTOTAL	25277148	16659978	24017345		24577267	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	93713		127128		65357	
c. CISS	0		0		0	
d. Abstinence Education	0		952204		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	99699355		97197188		103589773	
h. AIDS	0		0		0	
i. CDC	16573096		14178396		10987873	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
Early Childhood	140000		140000		150000	
Newborn Hearing	0		0		270000	
Other USDA Grants	58556096		58955098		62034218	
Personal Resp. Edu	0		0		997141	
Traumatic Brain Inj	0		313805		250000	
First Time Motherhoo	0		499572		0	
Home Visiting Grant	0		1578617		0	
Newborn Hearing	298937		300000		0	
Pers Respons Educ	0		991673		0	
Primary Care Offices	222727		0		0	
Rural Acces to Emer	100000		0		0	
Rural Hospital Flex	494547		0		0	
Sm Rur Hosp Improv	396000		0		0	
State Loan Repayment	150000		0		0	
State Office of Rur	180000		0		0	
Traumatic Brain	250000		0		0	

Inju						

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	972624	904140	7965990		7914894	
II. Enabling Services	6185659	5172286	5663786		4151293	
III. Population-Based Services	12003245	6000773	5032238		7105469	
IV. Infrastructure Building Services	6115620	4582779	5355331		5405611	
V. Federal-State Title V Block Grant Partnership Total	25277148	16659978	24017345		24577267	

A. Expenditures

The total Title V Block Grant amount awarded to the state in fiscal year 2009 was $14,185,831. From the amount awarded, $11,151,461 was expended in federal fiscal year 2009 due to carryovers from fiscal year 2008. The carryover amount from fiscal year 2008 was $1,870,404.

The amount of funds actually expended under the category "State Funds" was $2,615,249 more than the budgeted amount in fiscal year 2009. The increase in expenditures was due to a change in how match funding is reported for the Alternatives to Abortion and School Health programs.

The budgeted amount of $1,782,078 for the category "Pregnant Women" was less than the actual expenditures of $2,113,335 due to a change in how match funding is reported for the Alternatives to Abortion program.

The budgeted amount of $1,950,833 for the category "Infants < 1 Year Old" was more than the actual expenditures of $1,889,647 due to an increased number of vacant positions.

The budgeted amount of $9,365,476 for the category "Children 1-22 Years Old" was less than the actual expenditures of $10,541,095 due to a change in how match funding is reported for the School Health program.

The budgeted amount of $3,075,225 for the "All Others" category was more than the actual expenditures of $2,882,131 due to a change in how match funding is reported for Personal Services expenditures.

The budgeted amount of $1,399,118 for the category "Administration" was more than the actual expenditures of $1,277,205. This was due to an over estimation of expenditures for the year.

The budgeted amount of $1,028,275 for "Direct Care Services" was less than the actual expenditures of $1,206,994 due to a re-evaluation of the percentages used to distribute costs among the MCH Block pyramid types of service.

The budgeted amount of $6,407,900 for "Enabling Services" was more than the actual expenditures of $5,530,142 due to vacant positions and a re-evaluation of the percentages used to distribute costs among the MCH Block pyramid types of service.

The budgeted amount of $9,555,345 for "Population Based Services" was less than the actual expenditures of $11,569,777 due to a re-evaluation of the percentages used to distribute costs among the MCH Block pyramid types of service.

The budgeted amount of $8,833,684 for the category "Infrastructure Services" was more than the actual expenditures of $7,969,573 due to various reasons. There were vacant positions throughout the year. This, in turn decreased the amount of Administration costs. There was also decreased state funding in the areas of Core Public Health and the SAFE CARE program.

/2012/The total Title V Block Grant amount awarded to the state in fiscal year 2010 was $13,024,136. From the amount awarded, $11,788,960 was expended in federal fiscal year 2010 due to carryovers from fiscal year 2009. The carryover amount from fiscal year 2009 was $1,235,176.

The budgeted amount of $1,486,073 for the category "Pregnant Women" was less than the actual expenditures of $2,549,775 due to a change in how match funding is reported for the Alternatives to Abortion program.

The budgeted amount of $8,812,755 for the category "Children 1-22 Years Old" was less than the actual expenditures of $9,695,982 due to a change in how match funding is reported for the School Health program.

The budgeted amount of $7,418,103 for the "Children with Special Health Care Needs" category was more than the actual expenditures of $6,391,616 due to vacancies and a change in how match funding is reported for the Children with Special Health Care Needs program.

The budgeted amount of $8,875,575 for "Population Based Services" was less than the actual expenditures of $10,566,031 due to a change in how match funding is reported for the School Health program.

Expended amounts for State Funding showed a significant increase over the budgeted amount, due to a change in how match funding is reported for the Alternatives to Abortion, School Health, and Children with Special Health Care Needs programs. Expended amounts for Other Funds showed a significant decrease, but these funds are restricted and are not spent unless needed.//2012//

/2013/The total Title V Block Grant amount awarded to the state in fiscal year 2011 was $13,236,586. From the amount awarded, $9,402,185 was expended in federal fiscal year 2011 due to carryovers from fiscal year 2010. The carryover amount from fiscal year 2010 was $1,343,470.

The budgeted amount of $2,553,375 for the category "Pregnant Women" was more than the actual expenditures of $1,967,367 due to vacancies and reduced spending in the Alternatives to Abortion program. The reduction in Alternatives to Abortion was a result of a cut in FFY 2011 after it was moved to the Missouri Office of Administration.

The budgeted amount of $3,007,706 for the category "Infants < 1 Year Old" was more than the actual expenditures of $2,453,857 due to vacancies and reduced spending in the Alternatives to Abortion program. The reduction in Alternatives to Abortion was a result of a cut in FFY 2011 after it was moved to the Missouri Office of Administration.

The budgeted amount of $10,578,011 for the category "Children 1-22 Years Old" was more than the actual expenditures of $4,79,069 due to the elimination of the School Health Contracts totaling $4,560,612, reduction in the Core Public Health funding and vacant positions that were held.

The budgeted amount of $7,092,507 for the "Children with Special Health Care Needs" category was more than the actual expenditures of $6,161,504 due to vacancies and reduced spending in Core Public Health, Home Visiting and Child Care Contracts. The budgeted amount of $1,297,186 for the "Administration" category was more than the actual expenditures of $837,323 due to a change in the calculation of the Indirect on contractual expenditures.

The budgeted amount of $6,217,939 for "Enabling Services" was more than the actual expenditures of $5,172,286 due to vacancies and a reduction in Alternatives to Abortion expenditures. The reduction in Alternatives to Abortion was result of a cut in FFY 2011 after it was moved to the Missouri Office of Administration.

The budgeted amount of $12,008,093 for "Population Based Services" was more than the actual expenditures of $6,000,773, due to the elimination of the School Health Contracts totaling $4,560,612, reduction in the Core Public Health funding and vacant positions that were held.

Expended amounts for State Funding showed a significant decrease over the budgeted amount, due to vacancies, a change in how indirect for contractual expenditures are calculated and decreased spending due to State budget concerns. Expended amounts for Other Funds showed a significant decrease, but these funds are restricted and are not spent unless needed.//2013//

B. Budget

The state's maintenance of effort level from 1989 is $9,987,230 and the state's match requirement for fiscal year 2011 is $9,927,440. The state's match budget for fiscal year 2011 is $12,040,562.

The "Federal Allocation" category for fiscal year 2011 is $13,236,586. This figure is based on the fiscal year 2010 grant award since the final grant award for fiscal year 2011 has not yet been determined.

There is a budget variation in Fiscal year 2011 regarding "State Matching Funds." Due to a change in how match funding is reported, DHSS is including additional match of $1,324,865 over the Fiscal Year 2010 budgeted amount. The additional match is reflected in the total variance percentages. This type of increase is not expected for future years.

There were significant budget increases to the Pregnant Women, Infants less than one-year old, and Children ages 1-22 categories due to several factors. There were state budget increases to the Alternatives to Abortion program and the State Public Health Lab (SPHL) Personal Service (PS), which now funds 19 FTE. These increases coupled with the re-evaluation of funding distribution contributed to the vast percentage increase to the budget. There were decreases to the CSHCN and All Others categories due to re-evaluation of funding distribution.

There were significant budget increases in Direct Care Services, Enabling Services, and Population-Based Services due to several factors. There were state budget increases to the Alternatives to Abortion program and the SPHL PS, which now funds 19 FTE. These increases coupled with the re-evaluation of funding distribution contributed to the percentage increase to the budget. There was a budget decrease to Infrastructure due to re-evaluation of funding distribution.

/2012/Estimates have been used in providing FFY 2012 budget details. In the case of "type of individuals served", the budget is based upon a percentage breakdown by program and service area as to which types of individuals are impacted by the services provided. The program budgets take into account the "30-30-10" requirements of Title V. The State uses its MCH Block

Grant funds for the purposes outlined in Title V, Section 505 of the Social Security Act.

The state's maintenance of effort level from 1989 is $9,987,230 and the state's match requirement for fiscal year 2012 is $8,788,546. The state's match budget for fiscal year 2012 is $12,299,284.

The "Federal Allocation" category for fiscal year 2012 is $11,718,061. This figure is based on the fiscal year 2010 grant award, less anticipated federal budget cuts. We are using the fiscal year 2010 award as the basis, since the final grant award for fiscal year 2011 has not yet been determined.

There is a budget variation in fiscal year 2012 regarding "Federal Funds." Due to anticipated federal budget cuts, the federal funds requested are $1,518,525 less than the fiscal year 2011 budget request. In addition, "Other Funds" shows a significant increase in percentage. These funds are restricted and represent the amount anticipated to be spent for match in fiscal year 2012.

There were significant budget decreases to the Infants less than one-year old, Children ages 1-22, and CSHCN categories due to several factors. There were state budget decreases to the Core Public Health contracts and School Health contracts, and state and federal decreases to personnel costs, expense and equipment, and other contracts. Due to the aforementioned decreases in state funding, other sources of match were identified which resulted in a significant budget increase in the Other category.

There were significant budget decreases in Population-Based Services and Infrastructure due to several factors. There were state budget decreases to the Core Public Health contracts and School Health contracts, and state and federal decreases to personnel costs. Due to the aforementioned decreases in state funding, other sources of match were identified which resulted in a significant budget increase in the Direct Health Care Services category.//2012//

/2013/Estimates have been used in providing FFY 2013 budget details. In the case of "type of individuals served", the budget is based upon a percentage breakdown by program and service area as to which types of individuals are impacted by the services provided. The program budgets take into account the "30-30-10" requirements of Title V. The State uses its MCH Block Grant funds for the purposes outlined in Title V, Section 505 of the Social Security Act.

The state's maintenance of effort level from 1989 is $9,987,230 and the state's match requirement for fiscal year 2013 is $8,794,515. The state's match budget for fiscal year 2013 is $12,851,247.

The "Federal Allocation" category for fiscal year 2013 is $11,726,020. This figure is based on the fiscal year 2011 grant award, less estimated federal budget cuts. We are using the fiscal year 2011 award as the basis, since the final grant award for fiscal year 2012 has not yet been determined.

There were significant budget decreases to the Pregnant Women category. The Alternatives to Abortion Program is no longer under the Title V Director and has been removed from the fiscal year 2013 match budget. Due to the aforementioned decreases in state funding, other sources of match were identified which resulted in a significant budget increase in the CSHCN category.

There were significant budget decreases in Enabling Services of the pyramid. The Alternatives to Abortion Program is no longer under the Title V Director and has been removed from the fiscal year 2013 match budget. Due to the aforementioned decreases in state funding, other sources of match were identified which resulted in a significant

budget increase in the Population Based Services of the pyramid.//2013//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.